

SECTION 1915(c) WAIVER FORMAT

1. The State of North Carolina requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

This is a request for a model waiver.

a. ☐ Yes b. ☒ No

If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

This waiver is requested for a period of (check one):

a. ☐ 3 years (initial waiver)
b. ☒ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

a. ☐ Nursing facility (NF)
b. ☒ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)
c. ☐ Hospital
d. ☐ NF (served in hospital)
e. ☐ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of

DATE : _____

the select group(s) of individuals who would be otherwise eligible for waiver services:

- a. _____ aged (age 65 and older)
- b. _____ disabled
- c. _____ aged and disabled
- d. _____ mentally retarded
- e. _____ developmentally disabled
- f. X mentally retarded and developmentally disabled
- g. _____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

- a. _____ Waiver services are limited to the following age groups (specify):
- b. _____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
- c. _____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.
- d. X Other criteria. (Specify):

1) Waiver services are targeted to ensure at least 4% of new slots each Waiver year are utilized for de-institutionalization of persons residing in public or private ICF/MR facilities.

- e. _____ Not applicable.

DATE : _____

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.
6. This waiver program includes individuals who are eligible under medically needy groups.
a. X Yes b. ____ No
7. A waiver of §1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.
a. X Yes b. ____ No c. ____ N/A
8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.
a. X Yes b. ____ No
9. A waiver of the "statewide" requirements set forth in section 1902(a)(1) of the Act is requested.
a. ____ Yes b. X No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):
10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.
11. The State requests that the following home and community-based services, as described and

defined in Appendix B.1 of this request, be included under this waiver:

- a. X Case management
- b. Homemaker
- c. Home health aide services
- d. X Personal care services
- e. X Respite care
- f. X Adult day health
- g. X Habilitation
 - Residential habilitation
 - X Day habilitation
 - Prevocational services
 - X Supported employment services
 - Educational services
- h. X Environmental accessibility adaptations
- i. Skilled nursing
- j. X Transportation
- k. X Specialized medical equipment and supplies
- l. Chore services
- m. X Personal Emergency Response Systems
- n. Companion services

DATE : _____

o. ____ Private duty nursing

p. X Family training

q. ____ Attendant care

r. ____ Adult Residential Care

____ Adult foster care

____ Assisted living

s. ____ Extended State plan services (Check all that apply):

____ Physician services

____ Home health care services

____ Physical therapy services

____ Occupational therapy services

____ Speech, hearing and language services

____ Prescribed drugs

____ Other (specify):

t. X Other services (specify): **In-home aide; Vehicle Adaptations; Crisis Stabilization; Developmental Day Care; Therapeutic Case Consultation; Supported Living; Augmentative Communication; Live-In Caregiver; Interpreter Services**

u. ____ The following services will be provided to individuals with chronic mental illness:

____ Day treatment/Partial hospitalization

DATE : _____

_____ Psychosocial rehabilitation

_____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.
14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.
15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):
 - a. _____ When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).
 - b. _____ Meals furnished as part of a program of adult day health services.
 - c. X When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:

DATE : _____

- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
 1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);
 2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
 3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
- b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.
- c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
 1. Informed of any feasible alternatives under the waiver; and
 2. Given the choice of either institutional or home and community-based services.
- d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
- e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

- f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.
- g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.
- h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.
- i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. X Yes b. No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. Yes b. No N/A

18. The State assures that it will have in place a formal system by which it ensures the health and

welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

An effective date of 4/1/01 is requested.

19. The State contact person for this request is Carol Robertson, who can be reached by telephone at (919) 857-4031.

20. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____

Print Name: _____

Title: _____

Date: _____

DATE : _____

DATE: _____

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

_____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

_____ The waiver will be operated by _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

 X The waiver will be operated by **DMH/DD/SAS*** , a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

- **DMH/DD/SAS = Division of Mental Health/ Developmental Disabilities/ and Substance Abuse Services. See also Appendix A (1).**

DATE: _____

APPENDIX A (1) ADMINISTRATION

The CAP/MR-DD waiver was amended effective July 11, 1996 to allow the Division of Medical Assistance to delegate plan of care approval to the area programs (local Area MH/DD/SAS agencies).

The process for authorizing an area program, or, designated Lead Agency, to approve its plans is initiated by the Developmental Disabilities Section Operations and Fiscal Management Branch/CAP/MR-DD Office. The Branch Head sends a written request to the DMA CAP/MR-DD Manager that describes the respective area program's or designated Lead Agency's capacity to approve its plans. The request addresses the program's proficiency in the plan of care process and describes the program's plan approval procedures, including the position(s) responsible for making approval decisions. After receiving all required information, the DMA CAP/MR-DD Manager promptly reviews the recommendation and responds in writing to the Branch Head. The CAP/MR-DD Office notifies the area program or designated Lead Agency of the decision.

DMA monitors the plan of care approval process through monthly quality assurance activities as required by the waiver, while DMH/DD/SAS reviews the area program's or designated Lead Agency's operation of CAP/MR-DD waiver functions at least annually. DMA and DMH/DD/SAS share results of the monitoring activities and initiate corrective action as needed. DMA may revoke approval authority if it determines that the area program or designated Lead Agency is not in compliance with the waiver requirements. In the case of a revocation, the plan of care approval returns to the State Developmental Disabilities Section authority.

DMH/DD/SAS with approval from DMA has authority to reassign local lead agency responsibilities. This aligns the waiver with General Statute 122C-125.1. Refer to Attachment to Appendix A (1) page A-3.

§ 122C-125.1. Area Authority failure to provide services; State assumption of service delivery.

Statute text

At any time that the Secretary determines that an area authority is not providing minimally adequate services, in accordance with its annual service plan, to persons in need in a timely manner, or fails to demonstrate reasonable efforts to do so, the Secretary, after providing written notification of the Secretary's intent to the area board and providing the area authority an opportunity to be heard, may assume control of the particular service in question or of the area authority and appoint an administrator to exercise the powers assumed. This assumption of control shall have the effect of divesting the area authority of its powers in G.S. 122C-117 and all other service delivery powers conferred in the area authority by law as they pertain to this service. County funding of the area authority shall continue when the State has assumed control of a service area or of the area authority. At no time after the State has assumed this control shall a county withdraw funds previously obligated or appropriated to the area authority.

Upon assumption of control of service delivery, the Department shall, in conjunction with the area authority, develop and implement a corrective plan of action and provide notification to the area authority's board of directors of the plan. The Department shall also keep the county board of commissioners and the area authority's board of directors informed of any ongoing concerns or problems with the area authority's delivery of services.

(1995 (Reg. Sess., 1996), c. 749, s. 8.)

APPENDIX B - SERVICES AND STANDARDS**APPENDIX B-1: DEFINITION OF SERVICES**

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. X Case Management

 Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. Yes 2. No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. Yes 2. No

 X Other Service Definition (Specify): Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request. Additionally, Case Management may be provided while the recipient is in a hospital if it does not duplicate discharge planning activities and is provided up to 30 days

VERSION 06-95

prior to the recipient's discharge from the hospital.

DATE: _____

VERSION 06-95

b. ____ Homemaker:

____ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

____ Other Service Definition (Specify):

c. ____ Home Health Aide services:

____ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

____ Other Service Definition (Specify):

DATE : _____

VERSION 06-95

d. X Personal care services:

- X Assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

 Payment will not be made for personal care services furnished by a member of the individual's family.

 X Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

 X Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

 Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

 X A registered nurse, licensed to practice nursing in the State.

DATE : _____

Page B-4

VERSION 06-95

☒ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

☐ Case managers

☒ Other (Specify): **A Qualified Developmental Disabilities Professional when provided by an Area MH/DD/SAS or certified Private Provider Agency as specified in Appendix B-2.**

3. Frequency or intensity of supervision (Check one):

☐ As indicated in the plan of care

☒ Other (Specify): **Every 60 days by a Licensed Home Care Agency, or every month when provided by an Area MH/DD/SAS Program or certified Private Provider Agency.**

4. Relationship to State plan services (Check one):

☐ Personal care services are not provided under the approved State plan.

☐ Personal care services are included in the State plan, but with limitations. The waived service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

☒ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

DATE : _____

VERSION 06-95

____ Other service definition (Specify):

e. X Respite care:

____ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

 X Other service definition (Specify): **Attachment B-6**

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

DATE : _____

RESPITE CARE

Respite care is a service that provides periodic relief for a family or primary caregiver on an interim basis. It may not be used as a daily service in treatment planning. It must be used at irregular intervals if used as a periodic service. In order to be considered a primary caregiver the person must be principally responsible for the care and supervision of the individual, and must maintain his/her primary residence at the same address as the individual.

This service may be provided in the individual's home or in an out-of-home setting. The provision of respite care in terms of amount and location will be based on the individual's needs and include day and overnight services.

Limitations: Respite services may not be provided in group home settings (This does not exclude Facility-Based Respite Homes). Respite may not be billed when the respite provider does not have an awake respite worker on duty. Staff sleep time is not reimbursable unless considered as part of a daily rate. Individuals residing in group homes and adult care homes can only receive respite when visiting with family at their home. Individuals living alone or with a roommate cannot receive respite. Respite services may only be provided for the waiver recipient; other family members, such as siblings of the recipient, may not receive care by the provider while Waiver Respite Care is being provided/billed for the recipient. Respite Care may not be provided by the recipient's primary caregiver(s), parent(s), spouse, step-parent(s), foster parent(s), Supported Living Provider or person who resides in the recipient's primary place of residence.

Private home respite services serving individuals are subject to licensure under G. S. 122C, Article 2 when:

- (1) more than two individuals are served concurrently; or
- (2) either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month.

VERSION 06-95

Respite care will be provided in the following location(s) (Check all that apply):

 X Individual's home or place of residence

 X Foster home

 Medicaid certified Hospital

 Medicaid certified NF

 Medicaid certified ICF/MR

 Group home

 X Licensed respite care facility

 X Other community care residential facility approved by the State that its not a private residence (Specify type):

**State Operated Regional ICF/MR Center
Certified Respite Provider's Home**

 Other service definition (Specify):

f. X Adult day health:

 Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

DATE : _____

VERSION 06-95

X Other service definition (Specify): **Adult Day Health; Attachment B-8**

Qualifications of the providers of adult day health services are contained in Appendix B-2.

DATE : _____

Adult Day Health Services

Adult Day Health Services is a service furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regiment" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service. Services are provided in a certified Adult Day Health Care facility. This service is for adults who are aged, disabled, and handicapped who need a structured day program of activities and services with nursing supervision. It is an organized program of services during the day in a community group setting for the purpose of supporting an adult's independence, and promoting social, physical, and emotional well-being. Services must include health services and a variety of program activities designed to meet the individual needs and interests. Transportation to and from the service facility is provided or arranged for when needed and not otherwise available within the geographic area specified by the day health program.

g. X

Habilitation:

X Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

_____ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

X Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any

VERSION 06-95

physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

- ☐ Individuals will not be compensated for prevocational services.
- ☐ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

DATE : _____

VERSION 06-95

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

 Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

 X Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

- The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

VERSION 06-95

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1. X Yes2. No

 X Other service definition (Specify): **Supported Living;
Attachment B-14, B-15, B-16 and B-17.**

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

DATE : _____

Page B-15

Supported Living Services

Supported Living Services are supports needed for an individual in order for him/her to live in the community as independently as possible. Supported Living provides flexible, individually-tailored supports and assistance to meet the client's habilitation needs and to facilitate adequate functioning in their home and community. This habilitation service works towards meeting habilitative goals and objectives throughout the client's day and provides personal assistance which is incidental in nature.

These services are provided in the community, the individual's own home, his/her family home, or settings which include small community integrated alternative care settings.

The supports that may be furnished to an eligible individual consist of the following: Habilitation training and incidental personal assistance aimed at promoting the individual's acquisition, retention, or improvement of his/her skills in a variety of areas that directly affect one's ability to reside as independently as possible. Skill development includes:

Self-Care: Training or assistance in daily activities that enable a person to meet basic life needs such as food, hygiene, appearance, and health.

Independent Living: Training in activities that enable a person to participate in a full and varied life in the community such as meal preparation, home management, community resource utilization, and self-administration of medication.

Mobility: Training in activities that enable a person to move from one place to another in the home and community such as gross motor skills, fine motor skills, transfers, independent travel skills, and access/use of public transportation.

Socialization: Training in activities that enable a person to acquire new behaviors, increase fluency of skills, promote generalization of skills, and prevent regression of skill development.

Self-Direction: Training in activities that enable a person to manage and control his/her personal life such as decision making, initiation and follow-through of appointments, and self protection skills.

Transportation is provided as identified and needed for the accomplishment of goals and objectives established in the Treatment/Habilitation Plan, and as designated to be addressed through Supported Living Services. All community resources will be exhausted prior to the cost of transportation being incorporated into the service provision. The cost of this transportation is included in the rate paid to providers.

VERSION 06-95

Level I	Level II	Level III	Level IV
Behavior and social skills promote the individual's participation in community activities. The individual requires assistance and training in order to promote optimal functioning within the setting.	<p>The individual requires supervision and supports to access the community and activities of daily living.</p> <p>Supports may be needed to address behavioral issues.</p>	<p>Consultation or treatment by a psychologist is needed to address behavioral issues.</p> <p>Moderate to high level of assistance is needed to access the community and activities of daily living. May involve periodic health care intervention.</p> <p>Individual is totally dependent for the initiation and completion all activities of daily living.</p>	<p>Medical condition is chronic, requiring intense and frequent support from medical professionals.</p> <p>Behavior is of extreme intensity and frequency that continuous 24-hour 1:1 or greater staffing is needed, requiring a complex intervention plan.</p>
<u>NC SNAP = 3</u>	<p><u>NC SNAP = 3</u></p> <p>And</p> <p>Can express wants/needs on a limited basis. May only be understood by those who know the individual (with or without augmentative communication).</p> <p>Or</p> <p>Requires supervision or minimal assistance to ensure safety due to ambulation difficulties, or requires assistance with adaptive equipment or mobility aides.</p> <p>Or</p> <p><u>NC SNAP = 3</u></p> <p>in any area of Behavioral Supports</p>	<p><u>NC SNAP = 3</u></p> <p>in all areas of Behavioral Supports</p> <p>or</p> <p><u>NC SNAP = 4</u></p> <p>Or</p> <p><u>NC SNAP = 5</u></p> <p>in <u>Assistance Needed</u> for Daily Living Supports</p>	<p><u>NC SNAP = 5</u></p> <p>in any area of Health Care and/or <u>Behavioral Supports</u></p>

- Current evaluations are required to substantiate care needs indicated on the NC SNAP.
- Age-related criteria under Daily Living Supports are not factors in determining Supported Living levels.
- If the Team is requesting a different level of Supported Living than is justified by the NC-SNAP

DATE : _____

score, please refer to the Implementation of the new criteria for Supported Living policy. (B-17)
Implementation of the new criteria for Supported Living Levels
Effective with the 2001 CAP/MR-DD Waiver

Review:

All persons for whom the use of new Supported Living criteria will result in movement out of eligibility for daily Supported Living Levels will have his/her complete Plan of Care, NC-SNAP results, and any local justification for the specific daily Supported Living Level funding reviewed by DD Section Management with these possible outcomes:

To waive denial and approve CAP funding for the daily Supported Living Level requested.

To support denial of eligibility for the daily Supported Living Level funding and to work closely with locals to determine appropriateness of other services, and/or other sources of funding.

II. Persons whose level changes from more to less intensive daily Supported Living Level with the imposition of new criteria.

If there are questions or the level is contested, the Area Program will send information for review to Raleigh CAP Consultant. Unresolved issues will be reviewed by DD Management as above.

III. During the first six months of the waiver renewal, new recipients may also request review by the State CAP/MR-DD office for a higher Supported Living Level than is indicated by the NC-SNAP score. This process will be reviewed during that time to investigate a standard review criteria process that could be implemented at the local Lead Agency level.

IV. General Guidelines

All decisions for level of need will take into consideration the individual's Plan of Care.

Local programs will not have the independent authority to "ignore" the new criteria.

Following State review if there are still concerns the formal Medicaid Appeals process is available.

Individuals currently in service funded by CAP/MR-DD will have new criteria applied only at their annual review.

Transition

I. If the use of the new criteria results in a daily Supported Living Level change that decreases or eliminates funding, subsequently jeopardizing an individual's current living arrangement and which can not be addressed through other waiver funded services, approval can be obtained to continue services at the existing level for a period of up to six months. This request should be made through the State CAP/MR-DD office. During that time, the Area Program and the individual's team must work to identify either alternative sources of funding, or alternative acceptable living arrangements. State DD staff will be available to support the Area Program in these cases as requested.

h. X Environmental accessibility adaptations:

_____ Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

 X Other service definition (Specify): **Attachment B-19 and B-20**

Environmental Accessibility Adaptations

Environmental Accessibility Adaptations are equipment and physical adaptations to the recipient's home which are required by the needs of the recipient as documented in the Plan of Care, as necessary to ensure the health, welfare, and safety of the recipient, enable the recipient to function with greater independence in the home, and are of direct and specific benefit due to the disability of the recipient. Environmental modifications shall exclude those adaptations or improvements to the home which are not of direct and specific benefit to the recipient due to his/her disability, such as roof repair, plumbing, kitchen and laundry appliances, swimming pools, etc.

Under this waiver plan, home refers to a recipient's private residence. Exceptions to this requirement may be authorized by the State when documented in the Plan of Care as meeting the following criteria: the service would enable reunification of the recipient with family members, the item is portable and can be used in a number of settings and there is documentation that portable methods are not appropriate, and the modification is cost effective compared to other services that would be provided in an accessible environment.

Environmental modifications include:

- Installation, maintenance and repairs of ramps and grab-bars;
- Widening of doorways/passageways for handicap accessibility;
- Modification of bathroom facilities including handicap toilet, shower/tub modified for physically involved persons, bedroom modifications to accommodate hospital beds and/or wheelchairs;
- Modification of kitchen counters, home fixtures, electrical outlets, light switches, thermostats, shelves, closets, sinks, counters, and cabinets;
- Shatterproof windows;
- Floor coverings;
- Modifications to meet egress regulations;
- Alarm systems/alert systems including, auditory, vibratory, and visual to ensure the health, safety, and welfare of the person (*includes signaling devices for persons with hearing and vision loss*);
- Fences to ensure the health and welfare of a waiver recipient who lives in a private home and does not receive paid supervision 16 hours per day or more;
- Video cameras to ensure the health and welfare of a waiver recipient who must be visually monitored while sleeping for medical reasons, and who resides in a private home without paid supervision during sleep hours;
- Stair mobility devices;
- Barrier-free lift/pulleys/mobility devices;
- Stationary/built-in therapeutic table;
- Stationary ramps;

- Weather protective modifications;
- Other requirements of the applicable life safety and fire codes

The service will reimburse the purchase, installation, maintenance, and repair of environmental modifications and equipment. Repairs are covered when the cost is efficient compared to the cost of the replacement of the item only after coverage under warranty is explored.

Environmental modifications will only be provided as a waiver service when they are documented in the Plan of Care as necessary to meet the needs of the recipient, prevent institutionalization and payment is not available as part of a Medicaid state plan option.

In order to obtain approval for the requested Environmental Accessibility Adaptation the following process is utilized:

- Assessment/recommendation by an appropriate professional that identify the person's need(s) with regard to the Environmental Accessibility Adaptation(s) being requested. The Case Manager must insure that adequate/appropriate documentation is obtained to identify person needs, as well as types of adaptation required.
- Outcomes/goals related the consumer's/family's utilization and/or procurement of the requested adaptation(s) is included in the Plan of Care as appropriate.
- Copies of the information specified above, as well as a revised Cost Summary and T/HP Signature Page must be submitted to the approval agency in order to obtain approval of the requested Environmental Accessibility Adaptations.
- The area program maintains an invoice from the supplier/installer that shows the date the adaptation was provided to the client, a description of the adaptation and the cost including related charges (applicable charges for delivery, installation, and taxes). For adaptations that require permits for construction or installation, a receipt for the permit is required if the cost is claimed.

Qualification standards: The provider must be qualified to perform, repair, or maintain the modifications as demonstrated by professional certification or references. All services shall be provided in accordance with applicable State or local building codes.

The area program bills Medicaid for these items.

Limitations: The total cost of all Environmental Accessibility Adaptations provided in one year cannot exceed \$2,500.00. This service is provided only for clients living in a private residence.

VERSION 06-95

Fences and video cameras must be submitted to the State CAP-MR/DD Office for approval.
This service cannot be used to purchase locks.

DATE : _____

i. Skilled nursing:

 Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

 Other service definition (Specify):

j. X Transportation:

 Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

 X Other service definition (Specify): **B-22**

Transportation

Transportation services are offered in order to enable individuals served on the waiver to gain access to waiver and other community services/activities specified by the Plan of Care. This service can be provided when documented in the Plan of Care as necessary in order for the individual to participate in an inclusive community life. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized. Recreational activities may be covered only to the degree that they are not diversional in nature and are reflected in specific outcomes in the Plan of Care.

Limitation: This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. This service is only available to individuals living in private residences. Additional Medicaid payment will not be provided to Provider Agencies to provide transportation to and/or from the person's residence and the site of a habilitation service when payment is included in the established rate paid to the provider. In all cases, it must be clearly documented that without the use of this service, the individual would not have the opportunity to access. The cost of this service cannot exceed \$1,200/year.

VERSION 06-95

k. X Specialized Medical Equipment and Supplies:

_____ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

 X Other service definition (Specify): **Attachment B-24 Augmentative Communication and Attachment B25-B26 MR/DD Waiver Equipment and Supplies.**

l. _____ Chore services:

_____ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

_____ Other service definition (Specify):

Augmentative Communication

These devices are necessary when normal speech is non-functional and when physical impairments make a gestural system impossible or ineffective. An aided system requires access to a symbolic system that is separate from the body.

Selection of devices (and training outcomes for those devices) must be specific and based on age, cognitive ability, fine and gross motor ability, environmental need and presence or absence of sensory impairment.

The hardware and software needed to augment communication is divided into the following categories:

- Low Technology and Clinician-Made Devices
- High Technology, Commercially Available Dedicated Devices and Systems
- Standard Computer/Monitors and Operating Peripherals
- Computer Driven Devices, Operating Peripherals and Printers
- Mounting Kits and Accessories for each component
- Microphones
- Overlay Kits and Accessories
- Cassette Recorders
- Switches/Pointers/Access Equipment - all types, Standard and Specialized
- Keyboard/Voice Emulators/Keyguards
- Voice Synthesizers
- Carry Cases
- Supplies (Battery, Battery Charger)
- Power Strips
- Artificial Larynges

MR/DD Waiver Equipment and Supplies

MR/DD Waiver Equipment and Supplies include devices, controls, or appliances, specified in the Plan of Care, which enable clients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

The service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid State Plan and shall exclude those items which are not of direct benefit to the client and without which the client would be institutionalized. All items shall meet applicable standards of manufacture, design, and installation.

The service includes the following items:

- Category 1- Adaptive Positioning Devices: Standers, trays, and attachments; prone boards and attachments, positioning chairs and sitters, trays, and attachments; multi-function physiosystem, bolster rolls and wedges; motor activity shapes ; therapeutic balls; visualizer ball; physio roll; therapy mats when used in conjunction with adaptive positioning devices.
- Category 2- Mobility Aids: Walkers, attachments, and accessories not on the regular Medicaid Durable Medical Equipment (DME) list; swivel wheeled scoot-about, adaptive car seats for physically involved clients; lifts and lift systems not on the State DME list; customized/specialized wheelchairs/strollers, accessories and parts not on the State DME list; repair of specialized/customized wheelchairs not on the State DME list; portable telescoping ramps; mobile wheelchair ramps; splints/orthotics for adults (including replacement materials and repairs); prosthetic/orthopedic shoes and devices for adults; protective helmets for adults that are medically necessary.
- Category 3- Aids for Daily Living: Adaptive eating utensils (cups/mugs, spoons, forks, knives universal gripping aid for utensils, adjustable universal utensil cuff, utensil holder, non-skid inner lip plate, sloping deep plates, scooper, plate guards, non-skid pads for plate/bowl, wheel chair cup holders); adaptive eating equipment (adaptive, assistive devices/aids including adaptive switches and attachments); mobile and/or adjustable tables and trays for chairs, wheelchairs, and beds; adaptive toothbrushes; universal holder accessories for dressing, grooming, and hygiene; toilet trainer with anterior and lateral supports ; adaptive toileting chairs and bath chairs and accessories not on the State DME list; adaptive hygiene/dressing aids, adaptive clothing, non-disposable clothing protectors; reusable incontinence undergarments with disposable liners for individuals age two and above; dietary scales; food/fluid thickeners for dysphagia treatment; nutritional supplements that are taken by mouth such as those supplements covered by Medicaid for Home Infusion

Therapy/Tube feedings; enclosed beds that are medically necessary and are not on the State DME list (see limitation below); bed rails, assistive listening devices for the individuals with hearing and vision loss (TDD, large visual display devices, Braille screen communicators, FM systems, volume control large print telephones, teletouch systems), medication dispensing boxes.

- Category 4- Speech, Cognitive, Perceptual, and Motor Developmental Treatment/Therapy Aids: Specialized/adapted items necessary to improve visual-perceptual motor skills, improve integration processing abilities, improve communication abilities (that are not covered under the Augmentative Communication service definition), improve gross motor skills, develop reaching, and/or improve visual attention, focusing, and following.

In order to obtain approval for the requested MR/DD Waiver Supplies and Equipment the following is utilized:

1. Assessment/recommendation by an appropriate professional identifies the individual's need(s) with regard to the MR/DD Waiver Supplies and Equipment being requested. The Case Manager must insure that adequate/appropriate documentation is obtained to identify client needs, as well as the specific supplies/equipment required.
2. A physician's signature certifying medical necessity.
3. Outcomes/goals related to the client/family's utilization and/or procurement of the requested supplies/equipment.
4. Copies of the information specified above, as well as a revised Cost Summary and Plan of Care Signature Page must be submitted to the approval agency in order to obtain approval of the requested MR/DD Waiver Supplies and Equipment.
5. The area program maintains a copy of an invoice from the supplier that shows the date the supply/equipment was provided to the individual, and the cost including related charges (applicable charges for delivery, taxes, etc.). Copies of the documentation related to these items are not submitted to the approval agency.

m. X Personal Emergency Response Systems (PERS)

X PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

____ Other service definition (Specify):

n. ____ Adult companion services:

____ Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

____ Other service definition (Specify):

o. ____ Private duty nursing:

____ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are

VERSION 06-95

provided to an individual at home.

____ Other service definition (Specify):

p. X Family training:

X Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

____ Other service definition (Specify):

q.____ Attendant care services:

____ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

____ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

____ Other supervisory arrangements (Specify):

____ Other service definition (Specify):

r. ____ Adult Residential Care (Check all that apply):

____ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed ____). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

____ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not

VERSION 06-95

apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way, which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

- ☐ Home health care
- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ Speech therapy
- ☐ Medication administration
- ☐ Intermittent skilled nursing services
- ☐ Transportation specified in the plan of care
- ☐ Periodic nursing evaluations
- ☐ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

DATE : _____

VERSION 06-95

____ Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. X Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify): **Attachments B-33, B-34, B-35, B-36, B-37, B-38-B39 and B40 :Crisis Stabilization; In-Home Aide; Developmental Day Care; Interpreter Services; Vehicle Adaptations. Therapeutic Case Consultation; Live-In Caregiver**

t. ____ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached.

DATE : _____

Crisis Stabilization:

This support is a more intensive level of intervention service that provides close supervision to the client on an individual basis and assists during periods of time in which the client is presenting episodes of unmanageable and/or inappropriate behaviors which require specialized staff intervention. An individual may display extreme, maladaptive behaviors that are not anticipated, are temporary in nature, and are beyond the daily behaviors which are addressed through other supports.

It provides additional one-to-one supervision for the client as needed during an acute crisis situation so that the client can continue to participate in his/her daily routine without interruption. Crisis of this nature may be due to medication changes, reaction to family stress, or other trauma. By providing this service, an imminent institutional admission may be avoided while protecting the client from harming himself/herself or others.

While receiving this service, the client is able to remain in his/her place of residence, in the day program, or in respite care, while a crisis plan is developed and implemented. Crisis Stabilization staff will implement intervention plans as written by a psychologist and/or psychiatrist and which are directed at reducing the maladaptive behavior.

This service is offered in the setting(s) where the client receives services. This service may not be provided in a regional MR facility or in an ICF-MR/DD community based facility.

Crisis Stabilization is provided on an hourly basis for periods up to 14 consecutive days per episode. A psychologist or psychiatrist must order the amount and duration of the service with a new order for each episode.

In-Home Aide Services

In-Home Aide Services include general household activities, such as meal preparation and routine household care, provided by a trained Level I In-Home Aide, when the individual regularly responsible for these activities is temporarily absent or unable to carry out these activities. In-Home Aide Services at this level provide support to individuals and their families who require assistance with basic home management tasks, such as sweeping and mopping floors, dusting, making an unoccupied bed, cooking, shopping, paying bills, making minor household repairs, ironing and mending clothing.

Developmental Day Care Services

Developmental Day Care Services provides habilitation for preschool children and for school age children during non-school hours (before/after school and during school vacations). This service is designed to meet the developmental needs of the children in the areas of self-help, language and cognitive development, and psychosocial skills in order to facilitate their functioning in a less restrictive, more integrative setting. Requirements related to Part H of Individuals with Disabilities Education Act (IDEA), including the completion of an Individualized Family Service Plan (IFSP) and the provision of service coordination, must also be met.

The service is provided in a licensed day care facility or sanctioned school setting and not in the home of the client's family. Medicaid funding is used only for the client and for no other family member. This service is viewed as a habilitation service and not a "baby-sitting" service. Any childcare, which is provided, is secondary and only for the client. All Developmental Day Care Services are goal-directed with approved goals and objectives on the client's Plan of Care.

Qualifications: The developmental day program must be licensed by the N. C. Division of Facility Services (DFS) and/or accredited as a developmental day center by DMH/DD/SAS or be a day care program operated by the North Carolina public school system.

Interpreter Services

This service is designed to provide effective, accurate, and impartial receptive and expressive interpreter and/or transliterating services for a waiver recipient who is deaf, hard of hearing, or deaf and blind, using any specialized vocabulary needed by that recipient. Interpreting is specific to the recipient's disability and denotes a skill in communication between sign language and spoken language. Transliterating denotes a skill in communication between spoken English and English-like signing or non-audible spoken English. Tactile interpreting or close vision services are also provided under this service.

Service Units and Service Limitations

The unit of service is one hour. Only direct service to the recipient may be billed. Travel time, preparation time, and documentation time are not billable.

The total reimbursement under the Waiver will not exceed 24 hours per year.

Provider Participation Requirements/Qualifications

Interpreters for the deaf/blind must be certified/classified by one of the following organizations:

Registry of Interpreters for the Deaf (RID)

Testing, Evaluation and Certification Unit for Cued Language Transliterators (TECUnit)

North Carolina Interpreter Classification System

Vehicle Adaptations

Vehicle adaptations are devices, controls, or services which enable clients to increase their independence or physical safety, and which allow the client to live in their home. The repair, maintenance, installation, and training in the care and use, of these items is included. Vehicle adaptations, repairs, and maintenance of equipment shall be performed by the adaptive equipment manufacturer's authorized dealer according to manufacturer's installation instructions, and National Mobility Equipment Dealers' Association, Society of Automotive Engineers, and National Highway and Traffic Safety Administration guidelines. When appropriate, waiver recipients are referred to Vocational Rehabilitation Services to acquire vehicle adaptations.

The following types of adaptations to the vehicle are allowed:

- Door handle replacements;
- Door height/width alterations;
- Installation of a raised roof or related alterations to existing raised roof systems to improve head clearance;
- Lifting devices;
- Devices for securing wheelchairs or scooters;
- Devices for transporting wheelchairs or scooters;
- Adapted steering, acceleration, signaling, and braking devices only when recommended by a physician and a certified driving evaluator for people with disabilities, and when training in the installed device is provided by certified personnel;
- Handrails and grab bars; and
- Lowering of the floor of the vehicle.

THERAPEUTIC CASE CONSULTATION

Therapeutic Case Consultation provides the provision of expertise, training and technical assistance in a specialty area (psychology, behavioral analysis, therapeutic recreation, speech therapy, occupational therapy, physical therapy, or nutrition) to assist family members, care givers, and other service providers in supporting individuals with developmental disabilities who have long term habilitative treatment needs.

Under this model, family members and other paid/unpaid caregivers are trained by a licensed professional to carry out therapeutic interventions, which will provide consistency, therefore increasing the effectiveness of the specialized therapy. This service will also be utilized to allow specialists as defined to be an integral part of the treatment team by participating in team meetings and providing additional intensive consultation and support for individuals whose medical and/or behavioral/psychiatric needs are considered to be extreme or complex. The activities addressed below are not covered under the state plan.

Activities:

The activities outlined below take place with and without the consumer being present. These activities will be observed and assessed on at least a quarterly basis.

1. Observing the individual prior to the development/revision of the Support Plan to assess and determine treatment needs and the effectiveness of current interventions/support techniques.
2. Constructing a written Support Plan to clearly delineate the interventions and activities to be carried out by the family members, care givers and program staff. The Support Plan will detail strategies, responsibilities, and expected outcomes.
3. Training relevant persons to implement the specific interventions/support techniques delineated in the Support Plan and to observe the consumer, to record data, and to monitor implementation of therapeutic interventions/support strategies.
4. Reviewing documentation and evaluating the activities conducted by family members care givers, or program staff as delineated in Support Plan with revision of that Plan as needed to assure continued relevance and progress toward achievement of outcomes.
5. Training and technical assistance to family members, caregivers, and other individuals primarily responsible for carrying out the consumer's plan of care on the specific interventions/activities, delineated in Support Plan, outcomes expected and review procedures..
6. Participating in treatment team meetings.

Criteria

The individual's need for Therapeutic Case Consultation must be clearly reflected on the individual's Plan of Care. Therapeutic Case Consultation may not include direct therapy provided to Waiver consumers, nor duplicate the activities of other services that are available to the individual through the Medicaid State Plan.

Service Units and Service Limitations

The unit of service is a quarter hour, and is based on the needs of the individual as identified by treatment team and indicated on the Plan of Care. Travel time, written preparation, and telephone communications are not billable as separate items.

Therapists and paid para-professional caregivers are able to bill for their services concurrently. Training provided by the therapist to the QDDP is included in the habilitative service rate.

The total cost reimbursable under the Waiver will not exceed \$1,500 per Waiver year.

Provider Participation Requirements/Qualifications

The following types of Specialists are reimbursable as a Waiver service to individuals/agencies directly enrolled with the Division of Medical Assistance as CAP-MR/DD service providers.

Specialized Therapy Services

1. Psychology/Behavior Psychologist who is licensed by the State of North Carolina; or Licensed Psychological Associates who is licensed by North Carolina.
2. Speech Therapy: Speech Pathologist who is licensed by the State of North Carolina.
3. Occupational Therapy: Occupational Therapist who is licensed by the State of North Carolina
4. Physical Therapy: Physical Therapist who is licensed by the State of North Carolina.
5. Therapeutic Recreation: Therapeutic Recreational Specialist who is certified by the National Council for Therapeutic Recreation Certification.
6. Dietician who is licensed by the State of North Carolina.

Live-In Caregiver Services

Live-In Caregiver Service provides reimbursement for the additional costs of room and board when a caregiver who provides approved waiver services resides in the same household as the waiver recipient.

The caregiver cannot be related to the recipient by blood or marriage to any degree. Reimbursement is not available if the recipient lives in the caregiver's home or in a residence that is owned or leased by a provider of Medicaid services.

VERSION 06-95

Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

- ___ Physician services
- ___ Home health care services
- ___ Physical therapy services
- ___ Occupational therapy services
- ___ Speech, hearing and language services
- ___ Prescribed drugs
- ___ Other State plan services (Specify):

u. ___ Services for individuals with chronic mental illness, consisting of (Check one):

___ Day treatment or other partial hospitalization services (Check one):

___ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

- a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
- b. occupational therapy, requiring the skills of a qualified occupational therapist,
- c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

DATE : _____

VERSION 06-95

- d. drugs and biologicals furnished for therapeutic purposes,
- e. individual activity therapies that are not primarily recreational or diversionary,
- f. family counseling (the primary purpose of which is treatment of the individual's condition),
- g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

___ Other service definition (Specify):

___ Psychosocial rehabilitation services (Check one):

___ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level.

DATE : _____

Specific psychosocial rehabilitation services include the following:

- a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- b. social skills training in appropriate use of community services;
- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

- a. vocational services,
- b. prevocational services,
- c. supported employment services, and
- d. room and board.

___ Other service definition (Specify):

Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

___ This service is furnished only on the premises of a clinic.

___ Clinic services provided under this waiver may be furnished outside the clinic facility.
Services may be furnished in the following locations (Specify):

APPENDIX B-2**PROVIDER QUALIFICATIONS****A. LICENSURE AND CERTIFICATION CHART**

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

NCAC= North Carolina Administrative Code, GS= General Statute, APSM= Area Program Standards Manual

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Case Management	Local MH/DD/SAS or designated Lead Agency	GS-122C		<p>Worker Qualifications: The case manager must be a Qualified Developmental Disabilities Professional (QDDP) by meeting the following qualifications: the individual must be a graduate of a college or university with a baccalaureate degree in a discipline related to developmental disabilities and at least one year of supervised habilitative experience in working with individuals with developmental disabilities, <u>or</u> be a graduate of a college or university with a baccalaureate degree in a human service field and at least two years of supervised habilitative experience in working with individuals with developmental disabilities, <u>or</u> be a graduate of a college or university with a baccalaureate degree in a field other than one related to developmental disabilities and at least three years of supervised habilitative experience in working with individuals with developmental disabilities. Individuals not meeting the qualifications of a QDDP must be a graduate of a college or university with a baccalaureate degree in a field other than one related to developmental disabilities and be under the supervision of a QDDP.</p> <p>Case managers must have a criminal record check, healthcare registry check, and medical statement. Driving record must be checked if providing transportation.</p>

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
In home Aide I	Local area MH/DD/SAS	GS-122C		Worker Qualifications: Service providers must meet the North Carolina Developmental Disabilities (NCDD) core competencies. Client specific competencies to be met as identified by the individual's treatment team. Service providers must have a criminal record check, healthcare registry check, and medical statement. Must be under the supervision of a QDDP.
	Provider certified by local area MH/DD/SAS		Certified by local area MH/DD/SAS	
	Home care agency	10 NCAC 03L		Must meet the qualifications for an In-Home Aide I as defined in 21 NCAC 36 .0403.
Personal Care	Local area MH/DD/SAS	GS-122C		Worker Qualifications: Service providers must meet the NCDD core competencies. Client specific competencies to be met as identified by the individual's treatment team. Service providers must have a criminal record check, healthcare registry check, and medical statement. Driving record must be checked if providing transportation. Must be under the supervision of a QDDP. Family Member Qualifications: Same as worker qualifications.
	Provider certified by local area MH/DD/SAS		Certified by local area MH/DD/SAS	
	Home care agency	10-NCAS 03L		Must meet the qualifications for an In-Home Aide I as defined in 21 NCAC 36 .0403.
Developmental Day	Licensed Developmental Day Programs	GS-122C	Certified by local area MH/DD/SAS	Worker Qualifications: Service provided by a QDDP or trained individual with at least a high school diploma or high school equivalency certificate and is under the supervision of a QDDP. Service providers must meet the NCDD core competencies. Client specific competencies to be met as identified by the individual's treatment team. Service providers must have a criminal record check, healthcare registry check, and medical statement.
	Licensed Day Care programs	GS-110, article 7	Certified by local area MH/DD/SAS	
DATE :				Page B-48

	Day Care programs operated by NC Public School Systems		Certified by local area MH/DD/SAS	
--	--	--	--------------------------------------	--

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Institutional Respite	State regional MR facility	NC Division of Facility Services	ICF-MR certificate of participation	Qualifications: This type of respite must be provided in a Medicaid IFC/MR bed in a State regional mental facility. ICF-MR facility licensure outlined by GS 122C-26, GS 143B-147, APSM 40-2 and 10 NCAC 14K, 14L, 14M, 14N, 14O
Community- Based Respite	Local area MH/DD/SAS or	GS-122C		Worker Qualifications: Service providers meet NCDD core competencies. Client specific competencies to be met as determined by the individual's treatment team. Service providers must have a criminal record check, healthcare registry check, and medical statement. Driving record must be checked if providing transportation. Family Member Qualifications: Same as worker qualifications
	Providers certified by local area MH/DD/SAS	10NCAC 14V .5100 and .6300 when applicable	Certified by local area MH/DD/SAS	
Respite Nursing	Local area MH/DD/SAS	GS-122C		Worker Qualifications: RN or LPN Service providers must have a criminal record check, healthcare registry check, and medical statement. Driving record must be checked if providing transportation.
	Provider certified by local area MH/DD/SAS	10NCAC 14V .5100 and 6300 when applicable	Certified by local area MH/DD/SAS	
	Home care provider	10-NCAC 03L		Worker Qualifications: RN or LPN

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Day Habilitation	Local area MH/DD/SAS or	GS-122C		<p>Worker Qualifications: Service provided by a QDDP or trained individual with at least a high school diploma or high school equivalency certificate and is under the supervision of a QDDP. Service providers must meet the NCDD core competencies. Client specific competencies to be met as identified by the individual's treatment team.</p> <p>Service providers must have a criminal record check, healthcare registry check, and medical statement. Driving record must be checked if providing transportation.</p>
	Provider certified by local area MH/DD/SAS	10NCAC 14V .500 and .2300 where applicable	Certified by local area MH/DD/SAS	
Supported Employment	Local area MH/DD/SAS or	GS-122C		<p>Worker Qualifications: Service provided by a QDDP or trained individual with at least a high school diploma or high school equivalency certificate and is under the supervision of a QDDP. Service providers must meet the NCDD core competencies. Client specific competencies to be met as identified by the individual's treatment team.</p> <p>Service providers must have a criminal record check, healthcare registry check, and medical statement. Driving record must be checked if providing transportation.</p>
	Provider certified by local area MH/DD/SAS	10NCAC 14V .5800	Certified by local area MH/DD/SAS	

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Supported Living	Local area MH/DD/SAS or	GS-122C		<p>Worker Qualifications: Service provided by a QDDP or trained individual with at least a high school diploma or high school equivalency certificate and is under the supervision of a QDDP. Service providers must meet the NCDD core competencies. Client specific competencies to be met as identified by the individual's treatment team. Service providers must have a criminal record check, healthcare registry check, and medical statement. Driving record must be checked if providing transportation.</p> <p>Family Member Qualifications: Same as worker qualifications</p>
	Provider certified by local area MH/DD/SAS	10NCAC 14V .2100 .5600 and .6600 when applicable	Certified by local area MH/DD/SAS	
Environmental Accessibility Adaptation	Local area MH/DD/SAS	GS-122C		Meet applicable state and local building codes
Transportation	Local area MH/DD/SAS	Valid NC Driver's License		Insurance coverage as required by North Carolina law and driving record check.
MR/DD Waiver Supplies and Equipment	Local area MH/DD/SAS	GS-122C		
Personal Emergency Response System	PERS Agency			Must be able to provide 24-hour service.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Family Training	Local area MH/DD/SAS or	GS-122C		Worker Qualifications: Must have expertise as appropriate, in the field in which the training is being provided.
	Provider certified by local area MH/DD/SAS		Certified by local area MH/DD/SAS	
Augmentative Communicative Devices	Local area MH/DD/SAS	GS-122C		Qualifications: Augmentative Communicative Devices are obtained from supplier who meets applicable state and local requirements and regulations for licensure and/or certification for the type of device for which the supplier is providing the service. Devices must also be approved by a physician and speech/language pathologist licensed to practice in North Carolina.
Interpreter	Local area MH/DD/SAS or	GS-122C	GS-8B RID TEC Unit State Classification	
	Provider certified by local area MH/DD/SAS			
Therapeutic Case Consultation	Local area MH/DD/SAS	GS-122C		Worker Qualifications: Must hold appropriate NC license for PT,OT, ST, psychology, nutrition.; national certification for Recreation Therapy.
	Provider certified by local area MH/DD/SAS		Certified by local area MH/DD/SAS	
	Home care agency	10-NCAS 03L		

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Crisis Stabilization	Local area MH/DD/SAS or	GS-122C		<p>Worker Qualifications: Service provided by a QDDP or trained individual with at least a high school diploma or high school equivalency certificate who is under the supervision of a QDDP. Service providers must meet the NCDD core competencies and client specific competencies as identified by the individual's treatment team.</p> <p>Service providers must have a criminal record check, healthcare registry check, and medical statement. Driving record must be checked if providing transportation.</p>
	Provider certified by local area MH/DD/SAS			
Vehicle Adaptations	Local area MH/DD/SAS	GS-122C		Must meet safety codes if applicable to the modification being provided.
Live-In Caregiver	Local area MH/DD/SAS	GS-122C		<p>The live-in caregiver must meet the competencies as established according to the waiver service authorized to provide.</p> <p>Payment for the service is made to the authorized service provider.</p>
Adult Day Health	Adult Day Health Care facility		Certified as an Adult Day Health Care facility by Division of Aging	

Licensure/Accreditation When Applicable

*Licensure: Division of Facility Services license; GS-122C; Domiciliary Care Homes (10 NCAC 42B-42D) (10 NCA 18O); ICF-MR Group Home GS122C-26 APSM 40-2; ICF-MR Facility GS122C-26; Adult Day Activities Program (10 NCAC 14V); Sheltered Workshop (10 NCAC 14V); Supervised Living (10 NCAC 14V); Home Care 10 NCAC 03L; Day Care 10 NCAC 18I-Q.

Direct Care Staff Training/Competencies**Personal Supports and Habilitative Services****Basic Qualifications**: Refer to appendix B, pp. 44-50**Background checks**: Refer to appendix B, pp. 44-50**Competency**: Must complete classes and/or pass competency tests for all areas indicated below.

CORE		CLIENT SPECIFIC	
before starting work	Within <u>90</u> days	before starting work	Within <u>90</u> days or as specified
<u>Overview</u> <ul style="list-style-type: none"> • Client Rights • Abuse • Neglect • Confidentiality • BBP/Universal Precautions • Interaction and Communication Strategies • Incident/Accident Reporting • Role/Purpose/Philosophy of services CPR/First Aid (unless other trained person always available) <u>Type of Service and required documentation</u>	<ul style="list-style-type: none"> • Overview of Developmental Disabilities • Person-Centered Planning 	<u>Orientation</u> <ul style="list-style-type: none"> • DX/Needs • Approved Physical Interventions • Goals/outcomes • Behavior Concerns • Communication Techniques • Medical Concerns Seizures Allergies Medications • Med. Admin – <u>before</u> administering • Assistance with Self Admin • Routines -daily care -use of adaptive equipment -transfers/carries 	All Competencies specified in the individual's Plan of Care

Phase-In schedule for existing staff: All existing staff must meet the core competencies and client specific competencies as determined by the individual's treatment planning team within 3 months of the waiver approval date.

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

- ☐ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.
- ☒ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

SECTION 1915(c) WAIVER FORMAT

APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1. ☐ Low income families with children as described in section 1931 of the Social Security Act.
2. ☒ SSI recipients (SSI Criteria States and 1634 States).
3. ☐ Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4. ☒ Optional State supplement recipients
5. ☒ Optional categorically needy aged and disabled who have income at (Check one):
 - a. ☒ 100% of the Federal poverty level (FPL)
 - b. ☐ % Percent of FPL which is lower than 100%.

STATE: _____

C-1

DATE: _____

6. X The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

X A. Yes B. No

Check one:

- a. _____ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or
- b. X Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1)____ A special income level equal to:

_____ 300% of the SSI Federal benefit (FBR)

 % of FBR, which is lower than 300% (42 CFR 435.236)

\$ which is lower than 300%

(2)___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324.)

(4)___ Medically needy without spenddown in 209(b) States.
(42 CFR 435.330)

(5) X Aged and disabled who have income at:

a. X 100% of the FPL

b. ___% which is lower than 100%.

(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7. X Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. X Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

Foster children or children receiving adoption assistance

STATE:_____

C-3

DATE:_____

Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under §1924.

REGULAR POST-ELIGIBILITY RULES--§435.726 and §435.735

- o The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- o If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- o If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.
- o If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--§1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

1. X **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

a. Allowances for the needs of the

A.____ The following standard included under the State plan (check one):

(2)_____ Medically needy

(4)___ The following percent of the Federal poverty level):___%

\$ *

C. X The following formula is used to determine the needs allowance:

100% of the FPL

STATE:

greater than the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. ☐ SSI standard

B. ☐ Optional State supplement standard

C. ☐ Medically needy income standard

D. ☐ The following dollar amount:
\$ _____ *

* If this amount changes, this item will be revised.

E. ☐ The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.

F. ☐ The amount is determined using the following formula:

—

G. ☒ Not applicable (N/A)

3. Family (check one):

A. ☐ AFDC need standard

B. ☐ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C. ☐ The following dollar amount:
\$ _____ *

*If this amount changes, this item will be

STATE: _____

C-7

DATE: _____

State of North Carolina
revised.

STATE: _____

C-8

DATE: _____

State of North Carolina

D.____ The following percentage of the following standard that is not greater than the standards above: %____ of ____ standard.

E.____ The amount is determined using the following formula:

F.____ Other

G. X Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

STATE: _____

C-9

DATE: _____

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b)___**209(b) State, a State that is using more restrictive eligibility requirements than SSI.** The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A. ___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income
level for the institutionalized

(4)___ The following percentage of
the Federal poverty level:___%

(5)___ Other (specify):

B. ___ The following dollar amount:
\$___*

* If this amount changes, this item will be revised.

C. ___ The following formula is used to determine the amount:

-

STATE:_____

C-10

DATE:_____

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under §435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A.____ The following standard under 42 CFR 435.121: _____

B.____ The medically needy income
standard_____;

C.____ The following dollar amount:
\$_____*

* If this amount changes, this item will be
revised.

D.____ The following percentage of the following standard that is
not greater than the standards above: _____% of _____

E.____ The following formula is used to determine the amount:

-

F.____ Not applicable (N/A)

3. family (check one):

A.____ AFDC need standard

B.____ Medically needy income
standard

The amount specified below cannot exceed the higher of the
need standard for a family of the same size used to
determine eligibility under the State's approved AFDC plan
or the medically income standard established under 435.811
for a family of the same size.

C.____ The following dollar amount:
\$_____*

* If this amount changes, this item will be revised.

D.____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

E.____ The following formula is used to determine the amount:

—

F.____ Other

G.____ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2.____ The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a)____ SSI Standard

(b)____ Medically Needy Standard

(c)____ The special income level for the institutionalized

(d)____ The following percent of the Federal poverty level: _
____%

(e)____ The following dollar amount
\$ ____**

**If this amount changes, this item will be revised.

(f)____ The following formula is used _____ to
determine the needs
allowance:

—

(g)____ Other (specify):

—

STATE: _____

C-13

DATE: _____

State of North Carolina

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

STATE: _____

C-14

DATE: _____

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

☐ Discharge planning team

☒ Physician (M.D. or D.O.)

☐ Registered Nurse, licensed in the State

☐ Licensed Social Worker

☐ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

☐ Other (Specify):

DATE : _____

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

___ Every 3 months

___ Every 6 months

___ Every 12 months

X Other (Specify): **After initial evaluation, re-evaluation will be completed at the recipient's birthdate.**

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

___ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

X The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Licensed Social Worker

X Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

___ Other (Specify):

DATE : _____

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care
(Check all that apply):

- ☐ "Tickler" file
- ☐ Edits in computer system
- ☒ Component part of case management
- ☐ Other (Specify):

DATE : _____

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

- ☐ By the Medicaid agency in its central office
- ☐ By the Medicaid agency in district/local offices
- ☐ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program
- ☐ By the case managers
- ☐ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations
- ☐ By service providers
- ☒ Other (Specify): **Local Area MH/DD/SAS Program or designated Lead Agency**

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION / ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

DATE : _____

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

- ☒ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.
- ☐ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

DATE : _____

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
 - a. informed of any feasible alternatives under the waiver; and
 - b. given the choice of either institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.
3. The following are attached to this Appendix:
 - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
 - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
 - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
 - d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

Fair Hearing Process

Person who are not given the choice of home and community-based services (CAP-MR/DD) as an alternative to ICF/MR care or choose, but are not given, home and community-based services (CAP-MR/DD) as an alternative to ICF/MR care, or who are denied the service or provider of their choice are verbally notified to their right to a fair hearing. Each area program (lead agency) will have in writing the appeals process at the local and state level which contains:

Criteria for appeal:

Right to a hearing and who will hear the appeal;

Method to obtain a hearing;

Ability to have representation or to represent self;

Outline of Medicaid appeals policy (see attached);

Timelines of the appeals process.

Each participant will receive a copy of their rights at the time of eligibility screening for CAP-MR/DD. In addition, each participant will be notified of their appeal rights when denial, reduction, or termination of CAP-MR/DD services are made. Sample form attached.

The requirements of the appeals process meet or exceed the requirements for a fair hearing established at 42 C.F.R. Part 431, Subpart E.

SIGNATURES

The following signatures confirm the involvement of individuals in the development of this assessment and plan of care. All signatures indicate concurrence with the services/ supports to be provided.

<u>Title</u>	<u>Name / Signature</u>	<u>Date</u>
Individual	_____	_____
Family Representative	_____	_____
Case Manager	_____	_____
Single Portal Representative	_____	_____
LEA Representative	_____	_____
Clinician	_____	_____
_____	_____	_____

For CAP-MR/DD Funded Consumers Only:

- 1) I confirm/concur my involvement in the development of this assessment and plan of care. My signatures indicate concurrence with the services/supports to be provided.
- 2) I understand that I have the choice of seeking care in an intermediate care facility for the mentally retarded instead of participating in the Community Alternatives Program for the Mentally Retarded / Developmentally Disabled (CAP/MR-DD). I choose to participate in CAP/MR-DD.
- 3) I understand that I have the choice of service providers and may change service providers at anytime by contacting my case manager.

Individual: _____ Date: _____

Legally Responsible Person: _____ Date: _____

DATE : _____

EDS

April 14, 2000

RE:
MID:

Dear:

EDS, under contract by the Division of Medical Assistance (DMA), is responsible for reviewing services provided to North Carolina Medicaid recipients to ensure that each recipient receives quality services at the appropriate level of care. After careful review of the medical documentation, which accompanied the request for ICF/MR prior approval, the following was determined:

The request for prior approval for placement at the ICF/MR level of care has been denied. The medical records submitted indicate that the ICF/MR criteria were not met.

The criteria used in making this decision are available by calling EDS toll-free 1-800-688-6696.

If the above named individual or representative disagrees with the decision, he/she has the right to request an appeal from DMA. If an appeal is desired, the enclosed Appeal Request Form must be received at the DMA Hearing Office by _____.

Send the completed form to:

DMA Hearing Offices
Division of Medical Assistance
1985 Umstead Drive
Post Office Box 29529
Raleigh, North Carolina 27626-0529
FAX: (919) 715-3694

Following timely receipt of the appeal request, an informal hearing will be scheduled.

Relevant legislation and regulations can be found at the following cites: 43 USC 1396 a(a) (30), 1396 a(a) (31), 1396 a(a) (33) (A), 1396 a(a) (44), 1396 d(A) (15), 1396 d(A) (15), 1396 d(d): GS 108 A-25(b), 108 A-54, 108 A-55, : 42 CFR 431.200-213, 431.220-223, 431.230-232, 431.240-242, 431.244-246, 435.1009, 440.150, 440.230, 456.1-6, 456.350-350-351, 456.360, 456.370-372, 456.380-381, 483.440, 10 NCAC 26 A.0002, 26B .018, 26C .0005, 26D .0009, 26G.0101-0102, 26G .0104 (d), 261.0100-.0107.

cc: Carol Robertson DMA

4905 Waters Edge Drive
Raleigh, NC 27609

DATE : _____

Page D-9

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained: **Case Manager, Local Area MH/DD/SAS Program, designated Lead Agency, and DMH/DD/SAS DD Section.**

DATE : _____

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

☐ Registered nurse, licensed to practice in the State
☐ Licensed practical or vocational nurse, acting within the scope of practice under State law
☐ Physician (M.D. or D.O.) licensed to practice in the State
☐ Social Worker (qualifications attached to this Appendix)
☒ Case Manager
☐ Other (specify):

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

☐ At the Medicaid agency central office
☐ At the Medicaid agency county/regional offices
☒ By case managers
☐ By the agency specified in Appendix A
☐ By consumers
☒ Other (specify): **Local Area MH/DD/SAS Program or designated Lead Agency**

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

☐ Every 3 months

☐ Every 6 months

☒ Every 12 months

☐ Other (specify):

APPENDIX E-2**a. MEDICAID AGENCY APPROVAL**

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency: Attachment E-2, pages E-4 through E-17

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.
E-18 through E-26

*North Carolina Department of Health and Human Services Division of
Medical Assistance*

Quality Assurance Procedures

For

CAP – MR/DD

CAP-MR/DD Quality Assurance Procedures

The operation of the Community Alternatives program for Persons with Mental Retardation and other Developmental Disabilities (CAP-MR/DD) is a cooperative effort between the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS). DMH/DD/SAS is responsible for the day-to-day operation of the local CAP-MR/DD programs. It is a Federal requirement that CAP-MR/DD Plan of Care are subject to DMA review and approval. DMA has delegated approval authority to DMH/DD/SAS and Area Programs.

As the State's Medicaid agency, DMA has oversight responsibilities for the CAP-MR/DD program. As a part of these responsibilities, the Behavioral Health Services Unit in DMA conducts a quality assurance program to monitor and evaluate the plan of care review and approval activities. The QA program is part of the Federally approved home and community-based services waiver that authorizes North Carolina to operate CAP-MR/DD. In addition to the following QA process DMA will review the results of DMH Quality Assurance System and financial audits.

- ☐ These procedures are effective with the waiver year beginning December 2000.

Objectives of the Quality Assurance Program

The objectives of the QA program are outlined in the waiver and are conducted to ensure that:

- ☐ Clients approved for participation in the program meet eligibility criteria;
- ☐ Clients were given a choice between waiver participation and institutional care;
- ☐ Services are cost-effective according to program criteria;
- ☐ Services are appropriate to the client's needs;
- ☐ Services were provided according to the approved plan of care during the review month.
- ☐ Evidence that contingency plans have been established for emergencies and to accommodate backup when formal providers are unavailable;

Reporting Period

An overall report is prepared annually for the waiver year – December through November of the following year. Reports of each month's findings are prepared by DMA for review and any corrective action that seems appropriate is performed by the Audit Branch in DMH/DD/SAS following completion of the Quality Assessment Review for the month. It is these reports that are compiled to an annual overall report.

Sampling Procedures

1. Each month, DMA will select a random sample of CAP-MR/DD cases that were active on the last day of the review month. The sample will be selected three months from the end of the review month. The schedule is:

<i>Review Month</i>	<i>Sample Selected</i>	<i>Review Performed</i>
December	March 31	April
January	April 30	May
February	May 31	June
March	June 30	July
April	July 31	August

<i>Review Month</i>	<i>Sample Selected</i>	<i>Review Performed</i>
May	August 31	September
June	September 30	October
July	October 31	November
August	November 30	December
September	December 31	January
October	January 31	February
November	February	March

2. DMA will identify a minimum of 15 cases per month as review cases. Each Area Program will be reviewed at least once annually.

Reviewable Cases

1. Reviewable cases are active cases (defined as having an active CAP indicator on the State Eligibility Information System for the review month) operating under an approved plan of care, which have not been reviewed by DMA during the previous 12 months.
2. DMA will drop from the review category cases that have been reviewed by DMA during the previous 12 months and cases that were not active for at least a portion of the review month. Cases that are closed for CAP-MR/DD participation after the review month but before the review is completed will remain as reviewable cases.
3. Cases that are dropped will be replaced with cases from an over-sample list.
4. Any over-sample cases not used will be returned to the sampling universe for subsequent months.

Review Procedures

1. Consumers will be randomly selected for the review, and all names are placed on the List of Consumers Selected (Attachment I). The DMA Behavioral Health Unit will obtain recipient (consumer) profiles that show what Medicaid services were paid for the sample month for the consumers selected. If additional profiles are needed, they will be obtained as the need indicates.
2. The DMA Behavioral Health Unit will FAX a notification to each Area Program that has a review case. These sheets specify the information needed for the DMA reviewer and the date of the review.
3. Within ten (10) workdays from the date of the FAXED notification the area program informs DMA of any reason why the review should not take place, i.e. consumer not in their program etc.
4. Record reviews are either performed on site, in the case of multiple reviews for one Area Program, or the records are sent to DMA for a desktop review.

Objective

Clients approved for waiver participation meet eligibility criteria

How Objective is Reviewed

Reviewer looks for a current MR-2, documentation that the client is a risk of

institutionalization or was de-institutionalized, where client resides while on the program, and a current, approved Plan of Care.

Clients were given a choice between waiver participation and institutional care

Reviewer looks for client choice statement properly completed

Services are cost-effective according to program criteria

The cost summary in effect for the review month is reviewed

Services are appropriate to the client's needs

The Plan of Care and cost summary are reviewed

Contingency plans are in place for emergencies and to accommodate backup when formal providers are unavailable.

The plan of care is reviewed.

Services were provided according to the approved plan of care during the review month

The reviewer compares the Medicaid profiles to the cost summary to determine whether the client received the services that were on the plan of care that was in effect during the review month. Explanations of any changes in care that are provided by the case manager are considered

Reporting Procedures

1. DMA will e-mail a preliminary report to the Audit Branch of DMH/DD/SAS at the conclusion of each month's review. It will note the specific deficiencies found in cases. If the reviewer notes problems in local programs that could be placing consumers in jeopardy of health, safety, and well being, the Audit Branch will be contacted by phone immediately for intervention.
2. Based on the findings from reviews, DMA may request the Audit Branch to submit corrective action plans within 30 days of the date of the report letter.
3. The Audit Branch may request DMA to reconsider any finding included in the report. The request and all supporting documentation must be received by DMA within 30 days of the date of the report letter.
4. DMA will send the Audit Branch a final report within two weeks from the receipt of the reconsideration request and supporting documentation.
5. An annual report will be prepared by DMA and will site the specific deficiencies that were found in reviews. This annual report becomes part of the annual HCFA-372 report.

Attachments

QA Procedures for CAP-MR/DD List of Consumers Selected for CAP-MR/DD Quality Assurance Review

Review Month/Year _____

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F
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R
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w

<u>Consumer Name</u>	<u>Consumer MID #</u>	<u>Name of Area Program</u>	<u>FAX #</u>	<u>Fax Date</u>	<u>Review Date</u>	<u>Area Program Comment</u>
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
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18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						

Prepared by _____
Date _____

Date: _____



North Carolina
Department of Health and Human Services
Division of Medical Assistance
Medical Policy & Utilization Control
1985 Umstead Drive – 2511 Mail Service Center - Raleigh, N.C. 27699-2511
Courier Number 56-20-06

James B. Hunt, Jr., Governor
H. David Bruton, M.D., Secretary

Paul R. Perruzzi, Director

MEMORANDUM

TO: CAP MR/DD CASE MANAGER
Area Program

FROM: Nora Poisella
Behavioral Health Services

RE: Quality Assurance Review for Month/Year

CONSUMERS: _____

MID#: _____

DATE: _____

The Division of Medical Assistance (DMA) is responsible for conducting a quality assurance program to monitor and evaluate the plan of care review and approval activities for the Community Alternatives Program for the Mentally Retarded/Developmentally Disabled (CAP-MR/DD) consumers. The Quality Assurance program is part of the Federally approved home and community-based services waiver that authorizes The North Carolina Medicaid Program to operate CAP-MR/DD.

DMA has randomly selected the consumer listed above for a review of the care provided during the review month. I will be visiting your Program on _____. I will be contacting you to make arrangements within the next week.

Please review the enclosed information and have available for review.

Should you have any questions or require any assistance, please feel free to contact me at 919-857-4020.

cc: Cindy Kornegay, DMH/Audit Branch

ATTACHMENT IIa
CARReviewMemo
Revised 07/00

Date: _____



North Carolina
 Department of Health and Human Services
Division of Medical Assistance
Medical Policy & Utilization Control

1985 Umstead Drive – 2511 Mail Service Center - Raleigh, N.C. 27699-2511
 Courier Number 56-20-06

James B. Hunt, Jr., Governor
 H. David Bruton, M.D., Secretary

Paul R. Perruzzi, Director

MEMORANDUM

TO: CAP MR/DD CASE MANAGER
 Area Program

FROM: Nora Poisella
 Behavioral Health Services

RE: Quality Assurance Review for Month/Year

CONSUMERS: _____

MID#: _____

DATE: _____

The Division of Medical Assistance (DMA) is responsible for conducting a quality assurance program to monitor and evaluate the plan of care review and approval activities for the Community Alternatives Program for the Mentally Retarded/Developmentally Disabled (CAP-MR/DD) consumers. The Quality Assurance program is part of the Federally approved home and community-based services waiver that authorizes The North Carolina Medicaid Program to operate CAP-MR/DD.

DMA has randomly selected the consumer listed above for a review of the care provided during the review month. The enclosed CAP-MR/DD Quality Review Instruction Sheet outlines what is to be submitted to DMA.

The records are to be mailed to DMA by _____. Forward this information to my attention at the following address:

NORA POISELLA
 MEDICAL POLICY BEHAVIORAL HEALTH SERVICES
 DIVISION OF MEDICAL ASSISTANCE
 1985 UMSTEAD DRIVE, 2511 MAIL SERVICE CENTER
 RALEIGH, NC 27699-2511

Should you have any questions or require any assistance, please feel free to contact me at 919-857-4020.

cc: Cindy Kornegay, DMH/Audit Branch
 QAReviewMemo
 Revised 03/99

Date: _____

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

CAP-MR/DD QUALITY ASSURANCE RESPONSE SHEET**CONSUMER'S NAME:** _____ **REVIEW MONTH/YEAR:** _____**CONSUMER'S MEDICAID ID NUMBER:** _____**AREA PROGRAM:** _____

Please list below any deviations in service during the review month. A deviation includes no service provided, interruptions in the service, a greater or lesser amount of a service, a service provided but not billed for, and a service provided but not listed on the cost summary in effect for the review month. Attach additional sheets, if needed.

If there were no deviations in the services listed on the cost summary in effect, please check here ____.

Date: _____

SERVICE DEVIATIONS

NAME OF SERVICE	DATES COVERED BY DEVIATION*	IDENTIFY DEVIATION & REASON	HOW WERE NEEDS MET?

*Indicate the beginning and ending dates in the deviations of the service, i.e., 03/04/00 – 03/15/00.

Additional Comments: _____

CASE MANAGER'S SIGNATURE: _____ DATE: _____
 TELEPHONE NUMBER: _____

Date: _____

CAP-MR/DD QUALITY ASSURANCE REVIEW INSTRUCTION SHEET

The following information MUST be available to DMA for each case in effect for the review month.

1. MR-2 (For an initial Plan of Care, a copy of the EDS stamped, MR-2. For a CNR, a copy of the MR-2 in effect.)
2. A copy of the Plan of Care.
3. A copy of all summary revisions approved since the last Plan of Care.
4. Copies of CAP letters approving, denying, or requesting additional information for any initial, CNR, or revisions for cost summaries.
5. Copies of Case Manager's service notes for the month under review.
6. Complete the enclosed Response Sheet. If services were not provided during the review month as listed on the cost summary, written documentation indicating the particular services, date(s), and the deviation and reason is required to be submitted to DMA. Also, confirm whether the consumer's needs were met and if so, how or by whom. (A deviation in services includes no service being provided, interruptions in services, a greater or lesser amount of a service, a service provided but not billed for, and a service being provided but not listed on the cost summary in effect for the review month.)
7. If a Continued Need Review (CNR) was performed during the review month, complete records (#1,2,3 & 4 above) for both the current Plan Of Care in effect and next Plan Of Care in effect must be submitted.
8. If CAP services were terminated before the review month, written confirmation indicating the reason is required. If termination occurred during the review month, it is considered a reviewable case, and all the requested information must be submitted.

Your cooperation in submitting this needed information is appreciated. Should you have any questions, please contact Nora Poisella, RN, Behavioral Health Services at 919- 857-4020.

Date:_____

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE CONDUCTING THE CAP-MR/DD RECORD REVIEW

1. Answer questions 1 through 7 based on assessment/POC information.
2. Answer question 8 by adding the cost of waiver and regular Medicaid home and community care services provided during the review month and comparing the total to the cost limit. Cite a deficiency if the total exceeds the cost limit.
3. To answer question 9:
 - a. Compare the cost summary to the profile. Look at waiver services/items only; waiver services; purchases of waiver equipment/devices; waiver supplies and Medicaid medical supplies provided by the area program.
 - b. For services: Cite a deficiency if the services in the POC were not provided or were not provided in the approved amount and a satisfactory explanation for the deviation is not provided. (Deviations are usually justified when the service can't be provided due to the client being temporarily out of the home; during client crises that temporarily prevent service delivery; or during holidays or brief periods of time when the provider is not available. The unavailability of providers for long periods of time is not an acceptable explanation. There should be a back-up plan in place for emergencies or unavailability of a Provider. If services are not needed or desired by the family then a cost revision should be done or the client should be removed from CAP participation.
 - c. For equipment/devices: Cite a deficiency if waiver equipment/devices on the approved POC have not been purchased and a satisfactory explanation is not manufacturing/customizing an item for the client.)
 - d. For supplies: Cite a deficiency if the cost of waiver supplies and/or Medicaid medical supplies through the Area Program differs significantly from the cost on the approved POC and a satisfactory explanation if not provided.
 - e. For all waiver services: Cite a deficiency for any waiver service, category of supplies, equipment/device that was provided during the review month and was not on the approved POC.
 - f. For case management: If the approved POC says that case management will be provided monthly or more frequently, cite a deficiency if no case management is provided during the review month.
 - g. If any of the above cause deficiency #9 to be cited, do not add up hours, etc. or list inappropriately provided services.
4. Complete report, listing deficiency number beneath client's name. If deficiency #5, 6, or 7 is cited, provide a brief explanation.

CAP-MR/DD RECORD REVIEW FORM

Client: _____ MID #: _____
Area Program: _____ Sample Month/Year: _____

1. Record contains approved MR-2 (initial poc) or current MR-2 (CNR).
☐ Yes
☐ No
2. Client is either at risk of institutionalization or institutionalized in an ICF-MR (page 1 of treatment plan).
☐ Yes
☐ No
3. Client lives I or will be discharged to a private residence or an adult care home (Page 4).
☐ Yes
☐ No
4. Client or guardian has signed client choice statement (Page 16).
☐ Yes
☐ No
5. Client's living arrangement and the planned services and supports provide for the client's safety and well being (Page 4).
☐ Yes
☐ No
6. Appropriate medical care and services are planned to provide for the client's health and well being (Page 7).
☐ Yes
☐ No
7. The waiver services in the cost summary are appropriate according to the client's assessed needs (Page 15).
☐ Yes
☐ No
8. Medicaid home and community care services provided during the review month are within the cost limit (review profile).
☐ Yes
☐ No
9. The waiver services were provided during the review month as approved on the plan of care; or, the waiver services were not provided as approved but clarifying documentation was submitted that justifies deviation(s) from the approval plan of care.
☐ Yes
☐ No

Date: _____

North Carolina Division of Medical Assistance**CAP-MR/DD QA REVIEW
Descriptions of Deficiencies**

1. The record does not contain an approved MR-2 (initial poc) or a current MR-2 (CNR), whichever is appropriate for the month reviewed.
2. Client is not at risk of institutionalization in an ICF-MR or was not de-institutionalized from an ICF-MR.
3. Client does not live in a private residence or an adult care home.
4. The client or the client's guardian did not sign the client choice statement.
5. The client's living arrangement and the planned services and supports do not provide for the client's safety and well being.
6. The medical care and services to provide for the client's health and well being are not in the plan.
7. The client's assessed needs do not correspond to the waiver services in the cost summary.
8. The Medicaid home and community care services provided during the review month exceeded the cost limit.
9. The waiver services provided during the sample month do not correspond to the services on the plan of care that was in effect during the review month.

's Plan

NAME : _____
 NUMBER : _____

RECORD

Plan Meeting Date: ____ / ____ / ____

For Plan Approver Only

Plan Approved By: _____

Plan Approved Date: ____ / ____ / ____

Name (As appears on Medicaid Card)	Preferred Name
Area Program	Case Manager
Record Number / Unique ID	Date of Birth
Address	Phone
City, State, Zip	Medicaid County
Medicaid ID#:	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> African Am <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Am <input type="checkbox"/> Asian <input type="checkbox"/> Other	

TYPE <input type="checkbox"/> Initial Plan <input type="checkbox"/> Continued/Update <input type="checkbox"/> Transition CAP-MR/DD <input type="checkbox"/> At Risk for ICF/MR Placement <input type="checkbox"/> Previously in an ICF-MR bed SPECIAL FUNDING <input type="checkbox"/> MR/MI <input type="checkbox"/> At Risk Children <input type="checkbox"/> Other (Specify) <input type="checkbox"/> NC-SNAP SCORE	RESIDENCY <input type="checkbox"/> Private home with natural family <input type="checkbox"/> Individual Residence <input type="checkbox"/> Supervised Living ____ # of consumers <input type="checkbox"/> Adult Care Home ____ # of consumers <input type="checkbox"/> Child Foster Care <input type="checkbox"/> AFL /Therapeutic Home <input type="checkbox"/> ICF-MR <input type="checkbox"/> Other (Specify) <input type="checkbox"/> LOC Score
--	---

CONTACT PERSON <input type="checkbox"/> Next of Kin/ Relationship <input type="checkbox"/> Legally Responsible Person Type: Date of Action: <div style="text-align: center;">Name</div> <div style="text-align: center;">Address</div> <div style="text-align: center;">City, State, Zip</div> <div> <div>Phone (home)</div> <div>Phone (work)</div> </div>

PARTICIPANTS IN PLAN DEVELOPMENT

Date: _____

Page ____ of ____

NAME : _____

NUMBER : _____

_____’s Medical Information

RECORD

	CODE	DIAGNOSIS	Indicate Primary Diagnosis with “P”
AXIS I	_____	_____	_____
	_____	_____	_____
AXIS II	_____	_____	_____
	_____	_____	_____
AXIS III	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
AXIS IV	_____	_____	_____
AXIS V	_____	_____	_____

MEDICATION	DOSAGE & ROUTE	SCHEDULE	TARGET SYMPTOMS of THIS PERSON (Inc. Frequency, Intensity, Specificity)

ASSESSMENTS (Including Medical and Dental)	LAST DATE	APPROX. DUE DATE

NAME : _____

RECORD

NUMBER : _____

What has happened in _____'s life this past year (or if new plan, within the last few years)?
What goals have been met?

What does _____ want his/her life to be like? What is important? What are his/her goals?

NAME : _____
NUMBER : _____

RECORD

_____’s Plan

	Based on the person’s developmental, functional, physical and psychiatric status, what in his/her treatment or intervention routine makes sense/doesn’t make sense?	
	A. What are the person's strengths and preferences? B. What needs to be maintained/enhanced in living, work, relationships, safety, community life, medications, routine medical/dental care, equipment, etc.?	A. What are the person's problems and needs? B. What needs to change or be different in living, work, relationships, safety, community life, medications, routine medical/dental care, equipment, etc.?
from his/her perspective:		
from other people’s perspective:		

What do we need to know or do to support _____?

Page____ of ____

NAME : _____

RECORD NUMBER : _____

_____ 's Action Plan

This action plan is developed to help _____ meet his or her goals through addressing what needs to change and needs to be maintained identified on the previous pages.

____ Desired Personal, Clinical and/or Functional Outcome, including method of evaluation:

What	How	Who's Responsible	By When	Service and Frequency

____ Desired Personal, Clinical and/or Functional Outcome, including method of evaluation:

What	How	Who's Responsible	By When	Service and Frequency

Date: _____

NAME : _____

RECORD NUMBER : _____

(Repeat page as necessary)

_____ 's Case Management/Service Monitoring Plan

TYPE		FREQUENCY / CONTACT SCHEDULE
Face to Face:	Individual Family / Guardian Provider(s)	
Collaterals:	Individual Family / Guardian Provider(s) Education Others (residential/ vocational, etc.)	
	Service Observations / Visits Review of Service Documentation Review of Outcomes/Supports Strategies Review of Paid Claims Information Review of CM Indicator on Medicaid Card	
Other / Comments		

Attached are the following documents (check all that apply):

- NC-SNAP (required for new and renewal) ☐
- Staff Privileging/Training plan ☐
- Crisis Plan ☐
- Behavior Plan ☐
- Advanced Health/Mental Health Directive ☐
- Justification for Equipment or Supplies ☐
- Individual Education Plan (IEP) ☐
- Assessment of Personal Outcomes
and Supports ☐
- Individual and Family Service Plan ☐

Dates of
Quarterly Reviews
(if required)---

Date: _____

Other (Explain)

☐

Page____ of ____

NAME : _____

RECORD NUMBER : _____

SIGNATURES

The following signatures confirm the involvement of individuals in the development of this assessment and plan of care. All signatures indicate concurrence with the services/supports to be provided.

<u>Title</u>	<u>Name / Signature</u>	<u>Date</u>
Individual	_____	_____
Family Representative/ Legal Guardian	_____	_____
Case Manager	_____	_____
Single Portal Representative	_____	_____
LEA Representative	_____	_____
Clinician	_____	_____
_____	_____	_____
_____	_____	_____

For CAP-MR/DD Funded Consumers Only:

1) I confirm/concur my involvement in the development of this assessment and plan of care. My signatures indicate concurrence with the services/supports to be provided.

2) I understand that I have the choice of seeking care in an intermediate care facility for the mentally retarded instead of participating in the Community Alternatives Program for the Mentally Retarded / Developmentally Disabled (CAP/MR-DD). I choose to participate in CAP/MR-DD.

3) I understand that I have the choice of service providers and may change service providers at anytime by contacting my case manager

Individual: _____ Date: _____

Legally Responsible Person: _____ Date: _____

COST SUMMARY

EFFECTIVE DATE: _____ REVISION #: _____ REVISION EFFECTIVE DATE: _____
 List all services to be provided with the accompanying information. When payer is not Medicaid, enter a source code under "Source".
 If there is not a code, use 12, and describe: Use "V" for visits; "H" for hours; "D" for days; "W" for weeks; & "M" for months under
 "Frequency." Supplies & DME may be totaled here with details under "Comments" below.
 Does person receive special assistance? ☐ YES ☐ NO Number of hospitalizations during last 12 months: _____
 Clinical _____ Medical _____

Source Codes:		Cumulative Length of Stay:		
01 = Medicare	03 = Area DD Funds	05 = Family / Friends	07 = Vocational Rehabilitation	09 = SS/SSI/SA
02 = Insurance	04 = State DD Funds	06 = Client (non-covered services only)	08 = School System	10 = Willie M.

							AVER.
SERVICE	CODE	PROVIDER AGENCY	FREQUENCY	FROM / TO	UNIT RATE	CAP-MR/DD WAIVER SERVICES	OTHER MEDICAID
SUBTOTALS							
TOTAL MONTHLY MEDICAID (CAP-MR/DD WAIVER SERVICES + REGULAR MEDICAID)							
TOTAL ANNUAL MEDICAID (CAP/MR-DD AND/OR REGULAR MEDICAID X 12)							
TOTAL ANNUAL UCR-TS (MONTHLY SUBTOTAL X 12)							
TOTAL ANNUAL UCR-TS + TOTAL ANNUAL MEDICAID							

_____ 's Plan Update/Revision

NAME : _____

RECORD NUMBER : _____

What has happened in _____ 's life (personal or clinical) to cause the need for revision?
 Attach updated NC-SNAP if there are changes)

	Based on what is important to the person , the person's goals, and the person's clinical status, what in his/her life makes sense and what does not make sense?	
	A. What are the person's strengths & preferences? B. What needs to be maintained/enhanced in living, work, relationships, health and safety, community life, therapeutic and clinical, etc.?	A. What are the person's problems and needs? B. What needs to change or be different in living, work, relationships, health and safety, community life, therapeutic and clinical, etc.?
from his/her perspective		
from other people's perspective:		

_____ Desired Personal, Functional and/or Clinical Outcome based on what does/does not make sense, including method of evaluation:

What	How	Who's Responsible	By When	Service & Frequency

What do we need to know or do to support _____ differently?

Required Signature: The following confirms the involvement of the individual / guardian in the update of the plan including revision to the cost summary.

Individual Signature: _____ **Date:** _____

Legally Responsible Person: _____ **Date:** _____

Case Manager Signature: _____ **Date:** _____

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

☐ Registered nurse, licensed to practice in the State
☐ Licensed practical or vocational nurse, acting within the scope of practice under State law
☐ Physician (M.D. or D.O.) licensed to practice in the State
☐ Social Worker (qualifications attached to this Appendix)
☒ Case Manager
☐ Other (specify):

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

☐ At the Medicaid agency central office
☐ At the Medicaid agency county/regional offices
☒ By case managers
☐ By the agency specified in Appendix A
☐ By consumers
☒ Other (specify): **Local Area MH/DD/SAS Program or designated Lead Agency**

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

☐ Every 3 months

☐ Every 6 months

☒ Every 12 months

☐ Other (specify):

APPENDIX E-2**a. MEDICAID AGENCY APPROVAL**

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency: Attachment E-2, pages E-4 through E-17

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.
E-18 through E-26

*North Carolina Department of Health and Human Services Division of
Medical Assistance*

Quality Assurance Procedures

For

CAP – MR/DD

CAP-MR/DD Quality Assurance Procedures

The operation of the Community Alternatives program for Persons with Mental Retardation and other Developmental Disabilities (CAP-MR/DD) is a cooperative effort between the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS). DMH/DD/SAS is responsible for the day-to-day operation of the local CAP-MR/DD programs. It is a Federal requirement that CAP-MR/DD Plan of Care are subject to DMA review and approval. DMA has delegated approval authority to DMH/DD/SAS and Area Programs.

As the State's Medicaid agency, DMA has oversight responsibilities for the CAP-MR/DD program. As a part of these responsibilities, the Behavioral Health Services Unit in DMA conducts a quality assurance program to monitor and evaluate the plan of care review and approval activities. The QA program is part of the Federally approved home and community-based services waiver that authorizes North Carolina to operate CAP-MR/DD. In addition to the following QA process DMA will review the results of DMH Quality Assurance System and financial audits.

- ☐ These procedures are effective with the waiver year beginning December 2000.

Objectives of the Quality Assurance Program

The objectives of the QA program are outlined in the waiver and are conducted to ensure that:

- ☐ Clients approved for participation in the program meet eligibility criteria;
- ☐ Clients were given a choice between waiver participation and institutional care;
- ☐ Services are cost-effective according to program criteria;
- ☐ Services are appropriate to the client's needs;
- ☐ Services were provided according to the approved plan of care during the review month.
- ☐ Evidence that contingency plans have been established for emergencies and to accommodate backup when formal providers are unavailable;

Reporting Period

An overall report is prepared annually for the waiver year – December through November of the following year. Reports of each month's findings are prepared by DMA for review and any corrective action that seems appropriate is performed by the Audit Branch in DMH/DD/SAS following completion of the Quality Assessment Review for the month. It is these reports that are compiled to an annual overall report.

Sampling Procedures

1. Each month, DMA will select a random sample of CAP-MR/DD cases that were active on the last day of the review month. The sample will be selected three months from the end of the review month. The schedule is:

<i>Review Month</i>	<i>Sample Selected</i>	<i>Review Performed</i>
December	March 31	April
January	April 30	May
February	May 31	June
March	June 30	July
April	July 31	August

<i>Review Month</i>	<i>Sample Selected</i>	<i>Review Performed</i>
May	August 31	September
June	September 30	October
July	October 31	November
August	November 30	December
September	December 31	January
October	January 31	February
November	February	March

2. DMA will identify a minimum of 15 cases per month as review cases. Each Area Program will be reviewed at least once annually.

Reviewable Cases

1. Reviewable cases are active cases (defined as having an active CAP indicator on the State Eligibility Information System for the review month) operating under an approved plan of care, which have not been reviewed by DMA during the previous 12 months.
2. DMA will drop from the review category cases that have been reviewed by DMA during the previous 12 months and cases that were not active for at least a portion of the review month. Cases that are closed for CAP-MR/DD participation after the review month but before the review is completed will remain as reviewable cases.
3. Cases that are dropped will be replaced with cases from an over-sample list.
4. Any over-sample cases not used will be returned to the sampling universe for subsequent months.

Review Procedures

1. Consumers will be randomly selected for the review, and all names are placed on the List of Consumers Selected (Attachment I). The DMA Behavioral Health Unit will obtain recipient (consumer) profiles that show what Medicaid services were paid for the sample month for the consumers selected. If additional profiles are needed, they will be obtained as the need indicates.
2. The DMA Behavioral Health Unit will FAX a notification to each Area Program that has a review case. These sheets specify the information needed for the DMA reviewer and the date of the review.
3. Within ten (10) workdays from the date of the FAXED notification the area program informs DMA of any reason why the review should not take place, i.e. consumer not in their program etc.
4. Record reviews are either performed on site, in the case of multiple reviews for one Area Program, or the records are sent to DMA for a desktop review.

Objective

Clients approved for waiver participation meet eligibility criteria

How Objective is Reviewed

Reviewer looks for a current MR-2, documentation that the client is a risk of

	institutionalization or was de-institutionalized, where client resides while on the program, and a current, approved Plan of Care.
Clients were given a choice between waiver participation and institutional care	Reviewer looks for client choice statement properly completed
Services are cost-effective according to program criteria	The cost summary in effect for the review month is reviewed
Services are appropriate to the client's needs	The Plan of Care and cost summary are reviewed
Contingency plans are in place for emergencies and to accommodate backup when formal providers are unavailable.	The plan of care is reviewed.
Services were provided according to the approved plan of care during the review month	The reviewer compares the Medicaid profiles to the cost summary to determine whether the client received the services that were on the plan of care that was in effect during the review month. Explanations of any changes in care that are provided by the case manager are considered

Reporting Procedures

1. DMA will e-mail a preliminary report to the Audit Branch of DMH/DD/SAS at the conclusion of each month's review. It will note the specific deficiencies found in cases. If the reviewer notes problems in local programs that could be placing consumers in jeopardy of health, safety, and well being, the Audit Branch will be contacted by phone immediately for intervention.
2. Based on the findings from reviews, DMA may request the Audit Branch to submit corrective action plans within 30 days of the date of the report letter.
3. The Audit Branch may request DMA to reconsider any finding included in the report. The request and all supporting documentation must be received by DMA within 30 days of the date of the report letter.
4. DMA will send the Audit Branch a final report within two weeks from the receipt of the reconsideration request and supporting documentation.
5. An annual report will be prepared by DMA and will site the specific deficiencies that were found in reviews. This annual report becomes part of the annual HCFA-372 report.

Attachments

QA Procedures for CAP-MR/DD List of Consumers Selected for CAP-MR/DD Quality Assurance Review

Review Month/Year _____

I
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C
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e

F
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R
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v
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w

<u>Consumer Name</u>	<u>Consumer MID #</u>	<u>Name of Area Program</u>	<u>FAX #</u>	<u>Fax Date</u>	<u>Review Date</u>	<u>Area Program Comment</u>
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						

Prepared by _____
Date _____

Date: _____



North Carolina
Department of Health and Human Services
Division of Medical Assistance
Medical Policy & Utilization Control
1985 Umstead Drive – 2511 Mail Service Center - Raleigh, N.C. 27699-2511
Courier Number 56-20-06

James B. Hunt, Jr., Governor
H. David Bruton, M.D., Secretary

Paul R. Perruzzi, Director

MEMORANDUM

TO: CAP MR/DD CASE MANAGER
Area Program

FROM: Nora Poisella
Behavioral Health Services

RE: Quality Assurance Review for Month/Year

CONSUMERS: _____

MID#: _____

DATE: _____

The Division of Medical Assistance (DMA) is responsible for conducting a quality assurance program to monitor and evaluate the plan of care review and approval activities for the Community Alternatives Program for the Mentally Retarded/Developmentally Disabled (CAP-MR/DD) consumers. The Quality Assurance program is part of the Federally approved home and community-based services waiver that authorizes The North Carolina Medicaid Program to operate CAP-MR/DD.

DMA has randomly selected the consumer listed above for a review of the care provided during the review month. I will be visiting your Program on _____. I will be contacting you to make arrangements within the next week.

Please review the enclosed information and have available for review.

Should you have any questions or require any assistance, please feel free to contact me at 919-857-4020.

cc: Cindy Kornegay, DMH/Audit Branch

ATTACHMENT IIa
CARReviewMemo
Revised 07/00

Date: _____



North Carolina
 Department of Health and Human Services
Division of Medical Assistance
Medical Policy & Utilization Control

1985 Umstead Drive – 2511 Mail Service Center - Raleigh, N.C. 27699-2511
 Courier Number 56-20-06

James B. Hunt, Jr., Governor
 H. David Bruton, M.D., Secretary

Paul R. Perruzzi, Director

MEMORANDUM

TO: CAP MR/DD CASE MANAGER
 Area Program

FROM: Nora Poisella
 Behavioral Health Services

RE: Quality Assurance Review for Month/Year

CONSUMERS: _____

MID#: _____

DATE: _____

The Division of Medical Assistance (DMA) is responsible for conducting a quality assurance program to monitor and evaluate the plan of care review and approval activities for the Community Alternatives Program for the Mentally Retarded/Developmentally Disabled (CAP-MR/DD) consumers. The Quality Assurance program is part of the Federally approved home and community-based services waiver that authorizes The North Carolina Medicaid Program to operate CAP-MR/DD.

DMA has randomly selected the consumer listed above for a review of the care provided during the review month. The enclosed CAP-MR/DD Quality Review Instruction Sheet outlines what is to be submitted to DMA.

The records are to be mailed to DMA by _____. Forward this information to my attention at the following address:

NORA POISELLA
 MEDICAL POLICY BEHAVIORAL HEALTH SERVICES
 DIVISION OF MEDICAL ASSISTANCE
 1985 UMSTEAD DRIVE, 2511 MAIL SERVICE CENTER
 RALEIGH, NC 27699-2511

Should you have any questions or require any assistance, please feel free to contact me at 919-857-4020.

cc: Cindy Kornegay, DMH/Audit Branch
 QAReviewMemo
 Revised 03/99

Date: _____

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

CAP-MR/DD QUALITY ASSURANCE RESPONSE SHEET**CONSUMER'S NAME:** _____ **REVIEW MONTH/YEAR:** _____**CONSUMER'S MEDICAID ID NUMBER:** _____**AREA PROGRAM:** _____

Please list below any deviations in service during the review month. A deviation includes no service provided, interruptions in the service, a greater or lesser amount of a service, a service provided but not billed for, and a service provided but not listed on the cost summary in effect for the review month. Attach additional sheets, if needed.

If there were no deviations in the services listed on the cost summary in effect, please check here ____.

Date: _____

SERVICE DEVIATIONS

NAME OF SERVICE	DATES COVERED BY DEVIATION*	IDENTIFY DEVIATION & REASON	HOW WERE NEEDS MET?

*Indicate the beginning and ending dates in the deviations of the service, i.e., 03/04/00 – 03/15/00.

Additional Comments: _____

CASE MANAGER'S SIGNATURE: _____ DATE: _____
 TELEPHONE NUMBER: _____

Date: _____

CAP-MR/DD QUALITY ASSURANCE REVIEW INSTRUCTION SHEET

The following information MUST be available to DMA for each case in effect for the review month.

1. MR-2 (For an initial Plan of Care, a copy of the EDS stamped, MR-2. For a CNR, a copy of the MR-2 in effect.)
2. A copy of the Plan of Care.
3. A copy of all summary revisions approved since the last Plan of Care.
4. Copies of CAP letters approving, denying, or requesting additional information for any initial, CNR, or revisions for cost summaries.
5. Copies of Case Manager's service notes for the month under review.
6. Complete the enclosed Response Sheet. If services were not provided during the review month as listed on the cost summary, written documentation indicating the particular services, date(s), and the deviation and reason is required to be submitted to DMA. Also, confirm whether the consumer's needs were met and if so, how or by whom. (A deviation in services includes no service being provided, interruptions in services, a greater or lesser amount of a service, a service provided but not billed for, and a service being provided but not listed on the cost summary in effect for the review month.)
7. If a Continued Need Review (CNR) was performed during the review month, complete records (#1,2,3 & 4 above) for both the current Plan Of Care in effect and next Plan Of Care in effect must be submitted.
8. If CAP services were terminated before the review month, written confirmation indicating the reason is required. If termination occurred during the review month, it is considered a reviewable case, and all the requested information must be submitted.

Your cooperation in submitting this needed information is appreciated. Should you have any questions, please contact Nora Poisella, RN, Behavioral Health Services at 919- 857-4020.

Date:_____

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE CONDUCTING THE CAP-MR/DD RECORD REVIEW

1. Answer questions 1 through 7 based on assessment/POC information.
2. Answer question 8 by adding the cost of waiver and regular Medicaid home and community care services provided during the review month and comparing the total to the cost limit. Cite a deficiency if the total exceeds the cost limit.
3. To answer question 9:
 - a. Compare the cost summary to the profile. Look at waiver services/items only; waiver services; purchases of waiver equipment/devices; waiver supplies and Medicaid medical supplies provided by the area program.
 - b. For services: Cite a deficiency if the services in the POC were not provided or were not provided in the approved amount and a satisfactory explanation for the deviation is not provided. (Deviations are usually justified when the service can't be provided due to the client being temporarily out of the home; during client crises that temporarily prevent service delivery; or during holidays or brief periods of time when the provider is not available. The unavailability of providers for long periods of time is not an acceptable explanation. There should be a back-up plan in place for emergencies or unavailability of a Provider. If services are not needed or desired by the family then a cost revision should be done or the client should be removed from CAP participation.
 - c. For equipment/devices: Cite a deficiency if waiver equipment/devices on the approved POC have not been purchased and a satisfactory explanation is not manufacturing/customizing an item for the client.)
 - d. For supplies: Cite a deficiency if the cost of waiver supplies and/or Medicaid medical supplies through the Area Program differs significantly from the cost on the approved POC and a satisfactory explanation if not provided.
 - e. For all waiver services: Cite a deficiency for any waiver service, category of supplies, equipment/device that was provided during the review month and was not on the approved POC.
 - f. For case management: If the approved POC says that case management will be provided monthly or more frequently, cite a deficiency if no case management is provided during the review month.
 - g. If any of the above cause deficiency #9 to be cited, do not add up hours, etc. or list inappropriately provided services.
4. Complete report, listing deficiency number beneath client's name. If deficiency #5, 6, or 7 is cited, provide a brief explanation.

CAP-MR/DD RECORD REVIEW FORM

Client: _____ MID #: _____
Area Program: _____ Sample Month/Year: _____

1. Record contains approved MR-2 (initial poc) or current MR-2 (CNR).
☐ Yes
☐ No
2. Client is either at risk of institutionalization or institutionalized in an ICF-MR (page 1 of treatment plan).
☐ Yes
☐ No
3. Client lives I or will be discharged to a private residence or an adult care home (Page 4).
☐ Yes
☐ No
4. Client or guardian has signed client choice statement (Page 16).
☐ Yes
☐ No
5. Client's living arrangement and the planned services and supports provide for the client's safety and well being (Page 4).
☐ Yes
☐ No
6. Appropriate medical care and services are planned to provide for the client's health and well being (Page 7).
☐ Yes
☐ No
7. The waiver services in the cost summary are appropriate according to the client's assessed needs (Page 15).
☐ Yes
☐ No
8. Medicaid home and community care services provided during the review month are within the cost limit (review profile).
☐ Yes
☐ No
9. The waiver services were provided during the review month as approved on the plan of care; or, the waiver services were not provided as approved but clarifying documentation was submitted that justifies deviation(s) from the approval plan of care.
☐ Yes
☐ No

Date: _____

North Carolina Division of Medical Assistance**CAP-MR/DD QA REVIEW
Descriptions of Deficiencies**

1. The record does not contain an approved MR-2 (initial poc) or a current MR-2 (CNR), whichever is appropriate for the month reviewed.
2. Client is not at risk of institutionalization in an ICF-MR or was not de-institutionalized from an ICF-MR.
3. Client does not live in a private residence or an adult care home.
4. The client or the client's guardian did not sign the client choice statement.
5. The client's living arrangement and the planned services and supports do not provide for the client's safety and well being.
6. The medical care and services to provide for the client's health and well being are not in the plan.
7. The client's assessed needs do not correspond to the waiver services in the cost summary.
8. The Medicaid home and community care services provided during the review month exceeded the cost limit.
9. The waiver services provided during the sample month do not correspond to the services on the plan of care that was in effect during the review month.

NAME : _____

NUMBER : _____

's Plan

RECORD

Plan Meeting Date: ____ / ____ / ____

For Plan Approver Only
Plan Approved By: _____
Plan Approved Date: ____ / ____ / ____

Name (As appears on Medicaid Card)	Preferred Name
Area Program	Case Manager
Record Number / Unique ID	Date of Birth
Address	Phone
City, State, Zip	Medicaid County
Medicaid ID#:	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> African Am <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Am <input type="checkbox"/> Asian <input type="checkbox"/> Other	

TYPE <input type="checkbox"/> Initial Plan <input type="checkbox"/> Continued/Update <input type="checkbox"/> Transition CAP-MR/DD <input type="checkbox"/> At Risk for ICF/MR Placement <input type="checkbox"/> Previously in an ICF-MR bed SPECIAL FUNDING <input type="checkbox"/> MR/MI <input type="checkbox"/> At Risk Children <input type="checkbox"/> Other (Specify) <input type="checkbox"/> NC-SNAP SCORE	RESIDENCY <input type="checkbox"/> Private home with natural family <input type="checkbox"/> Individual Residence <input type="checkbox"/> Supervised Living ____ # of consumers <input type="checkbox"/> Adult Care Home ____ # of consumers <input type="checkbox"/> Child Foster Care <input type="checkbox"/> AFL /Therapeutic Home <input type="checkbox"/> ICF-MR <input type="checkbox"/> Other (Specify) <input type="checkbox"/> LOC Score
--	---

CONTACT PERSON	
<input type="checkbox"/> Next of Kin/ Relationship <input type="checkbox"/> Legally Responsible Person Type: Date of Action:	
Name	
Address	
City, State, Zip	
Phone (home)	Phone (work)

PARTICIPANTS IN PLAN DEVELOPMENT

Page ____ of ____

NAME : _____

NUMBER : _____

_____’s Medical Information

RECORD

	CODE	DIAGNOSIS	Indicate Primary Diagnosis with “P”
AXIS I	_____	_____	_____
	_____	_____	_____
AXIS II	_____	_____	_____
	_____	_____	_____
AXIS III	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
AXIS IV	_____	_____	_____
AXIS V	_____	_____	_____

MEDICATION	DOSAGE & ROUTE	SCHEDULE	TARGET SYMPTOMS of THIS PERSON (Inc. Frequency, Intensity, Specificity)

ASSESSMENTS (Including Medical and Dental)	LAST DATE	APPROX. DUE DATE

NAME : _____

RECORD

NUMBER : _____

What has happened in _____'s life this past year (or if new plan, within the last few years)?
What goals have been met?

What does _____ want his/her life to be like? What is important? What are his/her goals?

NAME : _____
NUMBER : _____

RECORD

_____’s Plan

	Based on the person’s developmental, functional, physical and psychiatric status, what in his/her treatment or intervention routine makes sense/doesn’t make sense?	
	A. What are the person's strengths and preferences? B. What needs to be maintained/enhanced in living, work, relationships, safety, community life, medications, routine medical/dental care, equipment, etc.?	A. What are the person's problems and needs? B. What needs to change or be different in living, work, relationships, safety, community life, medications, routine medical/dental care, equipment, etc.?
from his/her perspective:		
from other people’s perspective:		

What do we need to know or do to support _____?

Page____ of ____

NAME : _____

RECORD NUMBER : _____

_____ 's Action Plan

This action plan is developed to help _____ meet his or her goals through addressing what needs to change and needs to be maintained identified on the previous pages.

____ Desired Personal, Clinical and/or Functional Outcome, including method of evaluation:

What	How	Who's Responsible	By When	Service and Frequency

____ Desired Personal, Clinical and/or Functional Outcome, including method of evaluation:

What	How	Who's Responsible	By When	Service and Frequency

Date: _____

NAME : _____

RECORD NUMBER : _____

(Repeat page as necessary)

_____ 's Case Management/Service Monitoring Plan

TYPE		FREQUENCY / CONTACT SCHEDULE
Face to Face:	Individual Family / Guardian Provider(s)	
Collaterals:	Individual Family / Guardian Provider(s) Education Others (residential/ vocational, etc.)	
	Service Observations / Visits Review of Service Documentation Review of Outcomes/Supports Strategies Review of Paid Claims Information Review of CM Indicator on Medicaid Card	
Other / Comments		

Attached are the following documents (check all that apply):

- NC-SNAP (required for new and renewal) ☐
- Staff Privileging/Training plan ☐
- Crisis Plan ☐
- Behavior Plan ☐
- Advanced Health/Mental Health Directive ☐
- Justification for Equipment or Supplies ☐
- Individual Education Plan (IEP) ☐
- Assessment of Personal Outcomes
and Supports ☐
- Individual and Family Service Plan ☐

Dates of
Quarterly Reviews
(if required)---

Date: _____

Other (Explain)

☐

Page____ of ____

NAME : _____

RECORD NUMBER : _____

SIGNATURES

The following signatures confirm the involvement of individuals in the development of this assessment and plan of care. All signatures indicate concurrence with the services/supports to be provided.

<u>Title</u>	<u>Name / Signature</u>	<u>Date</u>
Individual	_____	_____
Family Representative/ Legal Guardian	_____	_____
Case Manager	_____	_____
Single Portal Representative	_____	_____
LEA Representative	_____	_____
Clinician	_____	_____
_____	_____	_____
_____	_____	_____

For CAP-MR/DD Funded Consumers Only:

1) I confirm/concur my involvement in the development of this assessment and plan of care. My signatures indicate concurrence with the services/supports to be provided.

2) I understand that I have the choice of seeking care in an intermediate care facility for the mentally retarded instead of participating in the Community Alternatives Program for the Mentally Retarded / Developmentally Disabled (CAP/MR-DD). I choose to participate in CAP/MR-DD.

3) I understand that I have the choice of service providers and may change service providers at anytime by contacting my case manager

Individual: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Source Codes:		Cumulative Length of Stay:		
01 = Medicare	03 = Area DD Funds	05 = Family / Friends	07 = Vocational Rehabilitation	09 = SS/SSI/SA
02 = Insurance	04 = State DD Funds	06 = Client (non-covered services only)	08 = School System	10 = Willie M.

[illegible]

_____ 's Plan Update/Revision

NAME : _____

RECORD NUMBER : _____

What has happened in _____'s life (personal or clinical) to cause the need for revision?
 Attach updated NC-SNAP if there are changes)

	Based on what is important to the person , the person's goals, and the person's clinical status, what in his/her life makes sense and what does not make sense?	
	A. What are the person's strengths & preferences? B. What needs to be maintained/enhanced in living, work, relationships, health and safety, community life, therapeutic and clinical, etc.?	A. What are the person's problems and needs? B. What needs to change or be different in living, work, relationships, health and safety, community life, therapeutic and clinical, etc.?
from his/her perspective		
from other people's perspective:		

_____ Desired Personal, Functional and/or Clinical Outcome based on what does/does not make sense, including method of evaluation:

What	How	Who's Responsible	By When	Service & Frequency

What do we need to know or do to support _____ differently?

Required Signature: The following confirms the involvement of the individual / guardian in the update of the plan including revision to the cost summary.

Individual Signature: _____ **Date:** _____

Legally Responsible Person: _____ **Date:** _____

Case Manager Signature: _____ **Date:** _____

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.
3. Method of payments (check one):

☒ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

☐ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

☐ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

☐ Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:
 - a. When the individual was eligible for Medicaid waiver payment on the date of service;
 - b. When the service was included in the approved plan of care;
 - c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

 X Yes

 No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

 X All claims are processed through an approved MMIS.

 MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

DATE : _____

APPENDIX F- Audit Trail

Description of Billing Process- Item b.1.

Payment of waiver claims is controlled by a waiver participation indicator in the eligibility information system (EIS). When a client is determined to be eligible for waiver participation, an indicator with an indicator effective date is placed in EIS to show waiver eligibility. It is terminated with a date of termination entered when waiver eligibility ceases. Claims for dates of service outside of the dates of waiver eligibility are denied.

Claims for waiver services are processed as follows:

1. The provider agency prepares the claim on a HCFA 1500 or prepares the claim for electronic transmission in the HCFA 1500 format.
2. The provider reviews the claim to be sure that the billed services agree with the services authorized by the local lead agency. Discrepancies are resolved. If the claim is a proper claim, the provider signs the claim and it is sent to EDS, the fiscal agency, for processing. The provider may choose to have a signature on file at EDS in lieu of signing each claim. The local lead agency reviews claims billed/paid to insure the services billed do not exceed the types/amounts authorized.
3. The claims processing system looks for the EIS waiver participation indicator before paying the claim. The system also subjects the claim to a number of audits to prevent duplication of services as well as payment of waiver services for dates of service while the client is institutionalized.

Post-payment reviews by DMA and DMH/DD/SAS look at the complete audit trail – the approval of the plan of care, the case manager's authorization to the provider to render approved services, service provision, service documentation and the provider's authorization for claims submission.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

_____ The Medicaid agency will make payments directly to providers of waiver services.

 X The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

_____ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

_____ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will **not** be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

DATE : _____

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	33,392	6,552	86,058	3,576
2	34,407	6,748	88,640	3,683
3	35,437	6,951	91,,299	3,794
4	36,452	7,159	94,038	3,908
5	37,552	7,374	96,859	4,025

DATE : _____

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR UNDUPLICATED INDIVIDUALS

1 6,527

2 6,527

3 6,527

4 6,527

5 6,527

EXPLANATION OF FACTOR C:

Check one:

_____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

 X The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

DATE : _____

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

This renewal includes services that will continue to be provided as they were throughout the current renewal period, services that were added or amended during that time, and new services.

The projected number of unduplicated recipients (column B) of each service was developed as follows:

- 1) For Case Management, Personal Care, Institutional Respite, In-Home Aide, Crisis Stabilization, Augmentative Communication, Supported Living Day, Non-Institutional Respite, Developmental Day, Adult Day Health, Environmental Adaptations, Waiver Supplies, PERS, Family Training, Vehicle Adaptations, and Respite-Nursing, are existing unchanged services, and are based on the MMIS data for the Base Year. The Base Year is based on actual paid claims through 11/2000 for the State Fiscal Year 7/99 – 6/00.
- 2) Day Habilitation Day is based on MMIS paid claims data for Adult Day Care at the proposed new rate for 1:3 ratio.
- 3) Day Habilitation Periodic is based on MMIS data for Pre-vocational periodic individual and group per actual utilization of individual and group 1 and group 2 services. Day Habilitation is replacing Pre-vocational service.
- 4) Supported Living Periodic replaces Community Inclusion Individual and Group and is based on MMIS data for those two services.
- 5) Transportation is a new service. Data based on a projection that 20% of all recipients will utilize this service, as it is not available to those who utilize day and residential services.
- 6) Therapeutic Case Consultation is a new service. Data is based on a projection that 75% of recipients who

DATE : _____

Page G-3

presently utilize outpatient treatment in the State Mental Health Plan would utilize this service.

- 7) Interpreter is a new service. Data is based on a projection that 1% of all recipients would utilize this service.
- 8) Live-In Caregiver is a new service. Data is based on a projection that 1% of all recipients would utilize this service.

The average number of units per user per year (column C) was developed by analyzing experience in the current waiver supplemented by estimates for the additional services needed by those participants discharged from institutional settings and those with more complex disabilities. For new services utilization projections have been based on professional judgement and experience in similar services.

The average unit cost (column D) is the results of developing a projected cost for the Base Year. The Base Year has been set as the State Fiscal Year 7/99 through year 6/00, based on actual paid claims from the MMIS through 11/00. A lag billing amount of 0.85% was applied based on the previous year's experience. From the Base Year an inflation rate of 2% was applied as a transition to reach Waiver Year 1 starting 3/01. Waiver Year 1 through 5 of the current renewal are then inflated by 3% per year respectively. The inflation figure is based on North Carolina's review of ICF/MR and Home Health costs. The projected costs for year 5 of the current renewal period were determined as follows:

- 1) For Case Management, Supported Living, MR Personal Care, Respite of all types, Developmental Day, In-home Aide, Crisis Stabilization, and Day Habilitation, information was based on actual average utilization rates in the Base Year, with a lag billing percentage of 0.85 applied, and inflated by 2% as described above.
- 2) Environmental Accessibility Adaptations, Waiver Supplies and Equipment, Augmentative Communication, Family Training and Vehicle Adaptations cover a variety of different items at different costs. Each service has been calculated utilizing actual paid claims data for average utilization per person per year. Environmental Accessibility was further adjusted allowing for an increase in the annual limit from \$1,500 to \$2,500 per year per person.
- 3) Transportation is based on a projected utilization for a capped limit of \$1,200 per year.
- 4) Therapeutic Case Consultation is based on costs found in the State Mental Health Plan for outpatient treatment with projected utilization rates applied.
- 5) Interpreter is based on an average rate of \$8.61 per quarter hour unit with a maximum utilization established at 24 hours per year.
- 6) Live-In Caregiver utilization is based on actual Supported Living utilization. The rate is based on room and board cost-finding in small ICF/MR settings, set at \$24.00 per day.

APPENDIX G-2

FACTOR D

LOC: _____

Demonstration of Factor D estimates:

Waiver Year 1 **X** 2__ 3__ 4__ 5__STATE: NORTH
CAROLINA**Demonstration of Factor D Estimates**
Waiver Year 1 (03/2001-02/2002)

Waiver Service	# Undup. Recip.	Avg. # + Type	Avg. Unit Cost	Total
<i>Column A</i>	<i>Column B</i>	<i>Units/User/Yr Column C</i>	<i>Column D</i>	<i>Column E</i>
Adult Day Health	31	125.9 Day	\$36.14	\$ 141,051
Augmentative Communication Device	219	1.4 Annual	\$1,520.86	\$ 466,296
Case Management	6,393	10.3 Month	\$509.00	\$ 33,516,581
Crisis Stabilization	15	517.5 1/4 hr. unit	\$6.03	\$ 46,808
Day Habilitation - Hourly rate	1,073	2,415.1 1/4 hr. unit	\$4.23	\$ 10,961,632
Developmental Day Program	358	1,249.7 1/4 hr. unit	\$5.70	\$ 2,550,138
Environmental Accessibility Adaptations	91	6.1 Annual	\$578.43	\$ 321,086
Family Training	94	66.3 1/4 hr. unit	\$6.20	\$ 38,640
In-Home Aide	29	1,027.0 1/4 hr. unit	\$3.28	\$ 97,688
Interpreter for Deaf	65	96.0 1/4 hr. unit	\$8.12	\$ 50,669
Live-in Care Giver	65	300.0 Day	\$20.00	\$ 390,000
MR Personal Care	1,385	2,989.1 1/4 hr. unit	\$3.28	\$ 13,578,883
MR Waiver Supplies	1,470	4.5 Annual	\$267.24	\$

DATE : _____

				1,767,793
Personal Emergency Response System (PERS)	17	9.8 Month	\$27.18	\$ 4,528
Respite - Institutional	19	30.8 Day	\$225.99	\$ 132,249
Respite - Non-Institutional	3,908	1,636.4 1/4 hr. unit	\$3.27	\$ 20,911,817
Respite - Nursing	104	1,635.2 1/4 hr. unit	\$8.46	\$ 1,438,714
Supported Employment	401	1,311.9 1/4 hr. unit	\$7.32	\$ 3,850,846
Supported Living Day	3,459	204.7 Day	\$108.68	\$ 76,951,667
Supported Living Periodic	3,170	2,815.1 1/4 hr. unit	\$5.47	\$ 48,813,552
Therapeutic Case Consultation	1,108	0.5 1/4 hr. unit	\$1,000.00	\$ 554,000
Transportation	1,305	0.7 Annual	\$1,200.00	\$ 1,096,200
Vehicle Adaptations	57	1.8 Annual	\$2,598.02	\$ 266,557
Grand Total (Column E)				\$ 217,947,397
Factor C (No. of Persons Served in Waiver Year)				6,527
Factor D (Divide sum of Column E by Factor C)				\$33,392
Average Length of Stay				336

STATE: NORTH
CAROLINA**Demonstration of Factor D Estimates
Waiver Year 2 (03/2002-02/2003)**

Waiver Service	# Undup. Recip.	Avg. # + Type Units/User/Yr	Avg. Unit Cost	Total
<i>Column A</i>	<i>Column B</i>	<i>Column C</i>	<i>Column D</i>	<i>Column E</i>
Adult Day Health	31	125.9 Day	\$37.22	\$ 145,266
Augmentative Communication Device	219	1.4 Annual	\$1,566.48	\$ 480,283
Case Management	6,393	10.3 Month	\$524.27	\$ 34,522,079
Crisis Stabilization	15	517.5 1/4 hr. unit	\$6.21	\$

DATE : _____

Page G-6

				48,205
Day Habilitation - Hourly rate	1,073	2,415.1 1/4 hr. unit	\$4.36	\$ 11,298,514
Developmental Day Program	358	1,249.7 1/4 hr. unit	\$5.88	\$ 2,630,668
Environmental Accessibility Adaptations	91	6.1 Annual	\$595.78	\$ 330,717
Family Training	94	66.3 1/4 hr. unit	\$6.38	\$ 39,761
In-Home Aide	29	1,027.0 1/4 hr. unit	\$3.38	\$ 100,667
Interpreter for Deaf	65	96.0 1/4 hr. unit	\$8.36	\$ 52,166
Live-in Care Giver	65	300.0 Day	\$20.60	\$ 401,700
MR Personal Care	1,385	2,989.1 1/4 hr. unit	\$3.38	\$ 13,992,874
MR Waiver Supplies	1,470	4.5 Annual	\$275.26	\$ 1,820,845
Personal Emergency Response System (PERS)	17	9.8 Month	\$27.99	\$ 4,663
Respite - Institutional	19	30.8 Day	\$232.77	\$ 136,217
Respite - Non-Institutional	3,908	1,636.4 1/4 hr. unit	\$3.37	\$ 21,551,323
Respite - Nursing	104	1,635.2 1/4 hr. unit	\$8.71	\$ 1,481,230
Supported Employment	401	1,311.9 1/4 hr. unit	\$7.54	\$ 3,966,582
Supported Living Day	3,459	204.7 Day	\$111.95	\$ 79,267,015
Supported Living Periodic	3,170	2,815.1 1/4 hr. unit	\$5.64	\$ 50,330,610
Therapeutic Case Consultation	1,108	0.5 1/4 hr. unit	\$1,030.00	\$ 570,620
Transportation	1,305	0.7 Annual	\$1,236.00	\$ 1,129,086
Vehicle Adaptations	57	1.8 Annual	\$2,675.96	\$ 274,553
Grand Total (Column E)				\$ 224,575,644
Factor C (No. of Persons Served in Waiver Year)				6,527
Factor D (Divide sum of Column E by Factor C)				\$34,407
Average Length of Stay				336

STATE: NORTH
CAROLINA

Demonstration of Factor D Estimates

Waiver Year 3 (03/2003-02/2004)

Waiver Service	# Undup. Recip.	Avg. # + Type Units/User/Yr	Avg. Unit Cost	Total
<i>Column A</i>	<i>Column B</i>	<i>Column C</i>	<i>Column D</i>	<i>Column E</i>
Adult Day Health	31	125.9 Day	\$38.34	\$ 149,637
Augmentative Communication Device	219	1.4 Annual	\$1,613.48	\$ 494,693
Case Management	6,393	10.3 Month	\$540.00	\$ 35,557,866
Crisis Stabilization	15	517.5 1/4 hr. unit	\$6.40	\$ 49,680
Day Habilitation - Hourly rate	1,073	2,415.1 1/4 hr. unit	\$4.49	\$ 11,635,396
Developmental Day Program	358	1,249.7 1/4 hr. unit	\$6.05	\$ 2,706,725
Environmental Accessibility Adaptations	91	6.1 Annual	\$613.66	\$ 340,643
Family Training	94	66.3 1/4 hr. unit	\$6.58	\$ 41,008
In-Home Aide	29	1,027.0 1/4 hr. unit	\$3.48	\$ 103,645
Interpreter for Deaf	65	96.0 1/4 hr. unit	\$8.61	\$ 53,726
Live-in Care Giver	65	300.0 Day	\$21.22	\$ 413,790
MR Personal Care	1,385	2,989.1 1/4 hr. unit	\$3.48	\$ 14,406,864
MR Waiver Supplies	1,470	4.5 Annual	\$283.52	\$ 1,875,485
Personal Emergency Response System (PERS)	17	9.8 Month	\$28.83	\$ 4,803
Respite - Institutional	19	30.8 Day	\$239.76	\$ 140,308
Respite - Non-Institutional	3,908	1,636.4 1/4 hr. unit	\$3.47	\$ 22,190,828
Respite - Nursing	104	1,635.2 1/4 hr. unit	\$8.97	\$ 1,525,445
Supported Employment	401	1,311.9 1/4 hr. unit	\$7.77	\$ 4,087,579
Supported Living Day	3,459	204.7 Day	\$115.30	\$ 81,639,007

VERSION 06-95

State of North Carolina

Supported Living Periodic	3,170	2,815.1 1/4 hr. unit	\$5.81	\$	51,847,667
Therapeutic Case Consultation	1,108	0.5 1/4 hr. unit	\$1,060.90	\$	587,739
Transportation	1,305	0.7 Annual	\$1,273.08	\$	1,162,959
Vehicle Adaptations	57	1.8 Annual	\$2,756.24	\$	282,790
Grand Total (Column E)				\$	231,298,282
Factor C (No. of Persons Served in Waiver Year)					6,527
Factor D (Divide sum of Column E by Factor C)					\$35,437
Average Length of Stay					336

STATE: NORTH
CAROLINA

Demonstration of Factor D Estimates
Waiver Year 4 (03/2004-02/2005)

Waiver Service	# Undup. Recip.	Avg. # + Type Units/User/Yr	Avg. Unit Cost	Total
<i>Column A</i>	<i>Column B</i>	<i>Column C</i>	<i>Column D</i>	<i>Column E</i>
Adult Day Health	31	125.9 Day	\$39.49	\$ 154,126
Augmentative Communication Device	219	1.4 Annual	\$1,661.88	\$ 509,532
Case Management	6,393	10.3 Month	\$556.20	\$ 36,624,602
Crisis Stabilization	15	517.5 1/4 hr. unit	\$6.59	\$ 51,155
Day Habilitation - Hourly rate	1,073	2,415.1 1/4 hr. unit	\$4.63	\$ 11,998,193
Developmental Day Program	358	1,249.7 1/4 hr. unit	\$6.23	\$ 2,787,256
Environmental Accessibility Adaptations	91	1.8 Annual	\$632.06	\$ 103,531
Family Training	94	66.3 1/4 hr. unit	\$6.77	\$ 42,192
In-Home Aide	29	1,027.0 1/4 hr. unit	\$3.58	\$ 106,623
Interpreter for Deaf	65	96.0 1/4 hr. unit	\$8.87	\$ 55,349
Live-in Care Giver	65	300.0 Day	\$21.85	\$ 426,075

DATE : _____

VERSION 06-95

State of North Carolina

MR Personal Care	1,385	2,989.1 1/4 hr. unit	\$3.58	\$	14,820,855
MR Waiver Supplies	1,470	4.5 Annual	\$292.02	\$	1,931,712
Personal Emergency Response System (PERS)	17	9.8 Month	\$29.70	\$	4,948
Respite - Institutional	19	30.8 Day	\$246.95	\$	144,515
Respite - Non-Institutional	3,908	1,636.4 1/4 hr. unit	\$3.57	\$	22,830,333
Respite - Nursing	104	1,635.2 1/4 hr. unit	\$9.24	\$	1,571,362
Supported Employment	401	1,311.9 1/4 hr. unit	\$8.00	\$	4,208,575
Supported Living Day	3,459	204.7 Day	\$118.76	\$	84,088,885
Supported Living Periodic	3,170	2,815.1 1/4 hr. unit	\$5.98	\$	53,364,725
Therapeutic Case Consultation	1,108	0.5 1/4 hr. unit	\$1,092.73	\$	605,372
Transportation	1,305	0.7 Annual	\$1,311.27	\$	1,197,845
Vehicle Adaptations	57	1.8 Annual	\$2,838.92	\$	291,273
Grand Total (Column E)				\$	237,919,034
Factor C (No. of Persons Served in Waiver Year)					6,527
Factor D (Divide sum of Column E by Factor C)					\$36,452
Average Length of Stay					336

STATE: NORTH
CAROLINA

Demonstration of Factor D Estimates
Waiver Year 5 (03/2005-02/2006)

Waiver Service	# Undup. Recip.	Avg. # + Type Units/User/Yr	Avg. Unit Cost	Total
<i>Column A</i>	<i>Column B</i>	<i>Column C</i>	<i>Column D</i>	<i>Column E</i>
Adult Day Health	31	125.9 Day	\$40.68	\$ 158,770
Augmentative Communication Device	219	1.4 Annual	\$1,711.74	\$ 524,819
Case Management	6,393	10.3 Month	\$572.88	\$

DATE : _____

				37,722,945
Crisis Stabilization	15	517.5 1/4 hr. unit	\$6.79	\$ 52,707
Day Habilitation - Hourly rate	1,073	2,415.1 1/4 hr. unit	\$4.77	\$ 12,360,989
Developmental Day Program	358	1,249.7 1/4 hr. unit	\$6.42	\$ 2,872,260
Environmental Accessibility Adaptations	91	1.8 Annual	\$651.03	\$ 106,639
Family Training	94	66.3 1/4 hr. unit	\$6.98	\$ 43,501
In-Home Aide	29	1,027.0 1/4 hr. unit	\$3.69	\$ 109,899
Interpreter for Deaf	65	96.0 1/4 hr. unit	\$9.14	\$ 57,034
Live-in Care Giver	65	300.0 Day	\$22.51	\$ 438,945
MR Personal Care	1,385	2,989.1 1/4 hr. unit	\$3.69	\$ 15,276,244
MR Waiver Supplies	1,470	4.5 Annual	\$300.78	\$ 1,989,660
Personal Emergency Response System (PERS)	17	9.8 Month	\$30.59	\$ 5,096
Respite - Institutional	19	30.8 Day	\$254.36	\$ 148,851
Respite - Non-Institutional	3,908	1,636.4 1/4 hr. unit	\$3.68	\$ 23,533,788
Respite - Nursing	104	1,635.2 1/4 hr. unit	\$9.52	\$ 1,618,979
Supported Employment	401	1,311.9 1/4 hr. unit	\$8.24	\$ 4,334,832
Supported Living Day	3,459	204.7 Day	\$122.33	\$ 86,616,650
Supported Living Periodic	3,170	2,815.1 1/4 hr. unit	\$6.16	\$ 54,971,021
Therapeutic Case Consultation	1,108	0.5 1/4 hr. unit	\$1,125.51	\$ 623,533
Transportation	1,305	0.7 Annual	\$1,350.61	\$ 1,233,782
Vehicle Adaptations	57	1.8 Annual	\$2,924.09	\$ 300,012
Grand Total (Column E)				\$ 245,100,956
Factor C (No. of Persons Served in Waiver Year)				6,527
Factor D (Divide sum of Column E by Factor C)				\$37,552
Average Length of Stay				336

APPENDIX G-3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Supported Living, MR Personal Care

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

- B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Respite

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

Rate setting process does not include room and board for these services.

DATE : _____

APPENDIX G-4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

_____ The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

 X The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

Additional costs of rent and food attributable to the unrelated caregiver is based on cost-finding of small community ICF/MR settings.

DATE : _____

Page G-13

APPENDIX G-5

FACTOR D'

LOC: ICF/MR

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

DATE : _____

Page G-14

APPENDIX G-5

FACTOR D' (cont.)

LOC: ICF/MR

Factor D' is computed as follows (check one):

☐ Based on HCFA Form 2082 (relevant pages attached).☐ Based on HCFA Form 372 for years ____ of waiver
____, which serves a similar target population.☐ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.☒ Other (specify): D' is projected utilizing data as reported from MMIS for years 1 through 4 of the current renewal period. The D' value of the current renewal period was re-calculated by dividing the sum of the total dollars spent on waiver recipients for all other Medicaid services by the number of waiver recipients. The re-calculated D' value for the Base Year was increased by 4.35% to account for lag billing calculated on the previous year's experience, and then inflated by 2% to arrive at Waiver Year 1. Inflation rates for Years 1 through 5 of 3% per year were used to project costs in this request. The inflation rate is determined by the state Division of Medical Assistance based on review of ICF/MR and home health costs.

DATE : _____

APPENDIX G-6

FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

- ☐ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.
- ☐ Based on trends shown by HCFA Form 372 for years ____ of waiver #____, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.
- ☐ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.
- ☐ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.
- ☒ Other (specify): Based on MMIS data, the Base Year value in the current renewal was increased by 0.12% for lag billing based on the previous year's experience, and then inflated by 2% to reach the beginning of Waiver Year 1. Inflation for Year 1 through 5 for this request is 3% each year respectively.
-
-

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

DATE : _____

Page G-16

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

DATE : _____

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

Factor G' is computed as follows (check one):

☐ Based on HCFA Form 2082 (relevant pages attached).☐ Based on HCFA Form 372 for years ____ of waiver
____, which serves a similar target population.☐ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.☒ Other (specify): Based on MMIS data, the G' value is calculated by dividing the sum of the total dollars spent on non-waiver recipients for acute care services to institutional long-term care recipients plus the total dollars spent on non-waiver recipients for non-institutional long-term care services, by the total number of non-waiver institutional care recipients. Lag billing percentage of 1.6% was applied based on the previous year's experience, and an inflation rate of 2% is applied to reach Waiver Year 1. The value is inflated by 3% for Years 1 through 5 respectively.

DATE : _____

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: ICF/MR

YEAR 1

FACTOR D: 33,392 FACTOR G: 86,058 FACTOR D': 6,552 FACTOR G': 3,576TOTAL: 39,943 ≤ TOTAL: 89,634

YEAR 2

FACTOR D: 34,407 FACTOR G: 88,640 FACTOR D': 6,748 FACTOR G': 3,683TOTAL: 41,155 ≤ TOTAL: 92,323

YEAR 3

FACTOR D: 35,437 FACTOR G: 91,299FACTOR D': 6,951 FACTOR G': 3,794TOTAL: 42,388 ≤ TOTAL: 95,093

DATE: _____

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY (cont.)

LOC: ICF/MR

YEAR 4

FACTOR D: 36,452FACTOR G: 94,038FACTOR D': 7,159FACTOR G': 3,908TOTAL: 43,611 \leq TOTAL: 97,945

YEAR 5

FACTOR D: 37,552FACTOR G: 96,859FACTOR D': 7,374FACTOR G': 4,025TOTAL: 44,926 \leq TOTAL: 100,884

DATE: _____